IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

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J.B.D.L. CORP. d/b/a BECKETT APOTHECARY, et al. : CIVIL ACTION

vs. :

WYETH-AYERST LABORATORIES, INC., et al. : NO. C-1-01-704

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MAY 18, 2004

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Videotape deposition of DAVID J. GIBSON, M.D., taken pursuant to notice, was held at the law offices of REED SMITH LLP, 2500 One Liberty Place, 1650 Market Street, Philadelphia, Pennsylvania 19103-7301, beginning at 10:19 a.m., before McKinley Wise, a Registered Professional Reporter and an approved Reporter of the United States District Court.

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I N D E X

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GIBSON EXHIBITS

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DEPOSITION SUPPORT INDEX

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(None)

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(Whereupon, Gibson Exhibit 1 was marked for identification.)

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THE VIDEOGRAPHER: Good morning. Here begins Videotape No. 1 in the deposition of David J. Gibson in the matter of J.B.D.L. versus Wyeth in the United States District Court, Southern District of Ohio.

Today's date is May 18th, 2004, and the time is 10:19 a.m. This deposition is being taken at One Liberty Place in the law offices of Reed Smith. The videographer is Michael Panichelli here on behalf of Esquire Deposition Services, located at 1880 JFK Boulevard, Philadelphia, Pennsylvania 19103.

Would counsel and all present please identify yourselves and state whom you represent.

MR. COHEN: Jay Cohen for direct purchaser plaintiffs.

MR. EINHORN: Gordon Einhorn for

Rite Aid and CVS.

MR. DOBIE: Gordon Dobie for the defendant Wyeth.

MS. WARD: Brooke Ward, also on behalf of the defendant Wyeth.

THE VIDEOGRAPHER: The court reporter is Mac Wise, and he will now swear in the witness.

* * *

DAVID J. GIBSON, M.D., after having been first duly sworn, was examined and testified as follows:

* * *

THE COURT REPORTER: Any statements for the record, counsel?

Hearing none, your witness, sir.

* * *

EXAMINATION

* * *

BY MR. DOBIE:

Q. Sir, would you state your name for the record?

A. David Gibson.

Q. Mr. Gibson, where do you reside?

A. Sacramento, California.

Q. And what's your address there?

A. 4830 Oak Vista Drive, Carmichael, California.

Q. And how long have you lived in Sacramento?

A. About seven years.

Q. Sir, I want to ask you some questions about the expert report that you've prepared in connection with this case, and we've gone ahead and marked it as Gibson Exhibit 1.

A. Thank you.

Q. Take a moment and look at that. Is that the expert report that you did, in fact, prepare in this case, sir?

A. It appears to be.

Q. And before we get into the substance of the report, let me just go over some ground rules for the deposition here today.

First, if you would be careful to let me finish my question before you begin to respond, even though you probably know where I'm going with my question or you think you may know. If we do that, it will be much easier for the

court reporter to get it down and we'll have a much clearer record. Fair enough?

A. I reread our prior meeting on the way out and I saw I stepped on your lines often, so I'll try to do better today.

Q. Okay. Second, if you can make sure you respond verbally to the questions, because again a nod of the head, an uh-huh just doesn't work that well on paper.

A. I understand.

Q. Okay. And finally if any of my questions are unclear, if you let me know, and I'll try to rephrase the question. Fair enough?

A. Fair enough.

Q. Before we get into the substance of the report, I want to talk with you a little bit more about your background, what you've been doing since the deposition that you gave in connection with the case Duramed versus -- versus Wyeth.

MR. DOBIE: And Jay, just as kind of a preliminary matter, with most of the depositions in the case or all the depositions, I think we've taken the position that depositions and documents from

the Duramed case can also be used in the -- in the J.B.D.L. and the other cases.

Is that fair enough with this witness? Because he does have a hundred-page report and I'm trying -- going to try to avoid going line -- line by line and covering things that I did last time unless I have to clarify a point or something like that.

MR. COHEN: Sure. That would be very much appreciated.

MR. DOBIE: Okay.

BY MR. DOBIE:

Q. Mr. Gibson, since your -- your last deposition, looking at your background, I notice you've undertaken some additional jobs, and one of them is mentioned on Page 6 of your report. Up at the top on Page 6 of your report, you state, "I have also started a second company, the Fraud Prevention Institute, that specializes in fraud prevention within the health care industry. FPI is made up of former Medi-Cal and FBI investigators who have been working on investigating and prosecuting fraudulent activity

within health care for many years."

So that's an -- that's an additional responsibility since your last deposition?

A. Correct.

Q. And your position with the Fraud Prevention Institute is chief executive officer?

A. Correct.

Q. And who are these FBI investigators and Medi-Cal investigators who are working for FPI?

A. The two principals would be a fellow by the name of Alan Cates, who is -- was appointed by the governor, our former governor, Davis, to head an investigative unit for the Department of Health Services to -- to find and help control fraud within the Medi-Cal program. And the second person is Ed O'Donnell, O-D-o-n-n-e-l-l, who was a special agent for -- in the FBI. He was awarded the -- he was awarded the outstanding agent of the year -- I may not have the exact award, but it was awarded by the FBI director to him as being the outstanding special agent on fraud investigations a couple of years ago.

Q. Now, here's where I'm -- I was a

little confused. Mr. Cates doesn't work for the Fraud Prevention Institute, does he?

A. No one works for the Fraud Prevention Institute at the present time. We have no employees. We have a -- it's a non -- not-for-profit company and each of us is either working on a nonpaid basis or as a consultant as we bring this company up from the start.

Q. And is Mr. Cates a -- it's a nonprofit. Are there -- do you have members, shareholders?

A. It's a business association is the rough classification for this. We have -- we have a not-for-profit shell in the state of California. We do not -- we have not yet cleared the hurdles with IRS and the franchise board.

* * *

(Whereupon, Gibson Exhibit 2 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Okay. let me show you what I've marked as Exhibit 2. Sir, I'm handing you what we marked as Exhibit 2. Exhibit 2 is a document that

we pulled off the Web on May 15th of 2004. This discuss an entity that's called the Medi-Cal Fraud Prevention Bureau and it mentions that Governor Davis had -- had appointed Alan Cates, who you mentioned, to be the director of the Medi-Cal Fraud Prevention Bureau. Do you see that?

A. I do.

Q. Okay. And it's the Medi-Cal Fraud Prevention Bureau, is it not, sir, that's in the business of investigating Medi-Cal fraud?

A. It is.

Q. All right. And the Medi-Cal Fraud Prevention Bureau is the group that has the FBI agents and others that are out investigating Medi-Cal fraud; correct?

A. It has in the past. That's correct.

Q. All right. And -- and continues to do so even today, doesn't it, sir?

A. It does.

Q. All right. And, for example, when we talk about Medi-Cal fraud, some of the things that -- that have been investigated recently, if you're familiar with it, is -- include physician and pharmacist fraud in California. Are you

familiar with that?
A. Uh-huh.
Q. And various -- I guess various prosecutions of physicians and people known as runners that are submitting or assisting in submission of fraudulent claims to Medi-Cal for payment?
A. Correct.
Q. Is that correct? And the group that you're involved in, FPI, sir --
A. Yes.
Q. -- that's actually something that was started four years ago; correct?
A. No. We got our -- we -- we incorporated last year, end of last year.
Q. Okay. You don't -- you don't work for the Medi-Cal Fraud Prevention Bureau, do you?
A. No.
Q. You don't have a contract with them?
A. No, we -- I do not.
Q. And -- and your group is not actually going out and investigating or prosecuting Medi-Cal fraud, is it, sir?
MR. COHEN: Object -- object to the

for fraudulent activity.
Q. The membership that you're talking about, the 70 members, does that include -- you said the United Pharmacist Network. Who else?
A. That's it.
Q. That's it?
A. That's our first contract.
Q. All right.
MR. COHEN: Just for clarification, I think he said 70. Did you say seven members?
THE WITNESS: 70.
MR. COHEN: I'm sorry. I misheard.
THE WITNESS: And these are mostly independent pharmacies.
MR. COHEN: Okay.
THE WITNESS: Community-based.
BY MR. DOBIE:
Q. But those 70 pharmacies are all members of this United Pharmacist Network?
A. Correct.
Q. So your contract is with United Pharmacist Network?
A. That's correct.

form as in what you referred to as "your group."
BY MR. DOBIE:
Q. The FPI?
A. I'll try to be brief. This could be a long discussion. But Fraud Prevention Institute is -- takes the experience from the Fraud Prevention Bureau and moves it into a different sphere. The Fraud Prevention Bureau was involved in prosecution of -- and felonies. The Fraud Prevention Institute deals in the arena of contract law, and the way the Fraud Prevention Institute works is it is funded by membership in a network of health care providers who contractually agree to not engage in fraudulent activities, and we monitor those activities.
Q. How many members do you have right now, sir?
A. At present, we have about 70. We've started with an organization in Los Angeles called UPNI, or United Pharmacist Network, Inc. And we're working with them to position them as a recognized nonfraudulent network in an area of California that has been a hot spot in the past

Q. All right. You don't have a contract with the Medi-Cal Fraud Prevention Bureau?
A. No, we do not. We would like to have a contract with the Department of Health Services, but we do not as yet have that.
* * *
(Whereupon, Gibson Exhibit 3 was marked for identification.)
* * *
BY MR. DOBIE:
Q. All right. Let me show you what's been marked as Exhibit 3. Have you ever seen this document before, sir?
A. No, I have not.
Q. This is -- I'll represent to you for the record this is a document that again we pulled off the Web relating to the United Pharmacist Network that you were just referring to and it also discusses this group FPI.
Let me ask you to turn -- the pages aren't numbered -- to the fourth page. At the bottom, it says "The Fraud Prevention Institute." Do you see that?

A. I do.
Q. And it turns over to the next page. And going to the third paragraph, it talks about "A recent four-year pilot of the FPI approach by the Medi-Cal Fraud Prevention Bureau involving over 6,000 providers eradicated over $300 million in fraud with undue disruption to the normal" -- "without undue disruption to the normal operations of the vast majority of honest providers." Do you see this?
A. I do, yes.
Q. Okay. Now, you mentioned that this FPI group was just created in 2003. Are you familiar with any four-year pilot that began all the way in I guess the year 2000 by FPI?
A. It doesn't say that. What it says is that the recent four-year pilot of the FPI approach and the methodology that FPI came out of the ground with was the technology developed by the Fraud Prevention Bureau under Alan Cates' directorship.
Q. Okay. The technology that we're talking about is something called the Safe Provider Program?

A. Correct.
Q. And that's the -- that's the idea that you -- that you developed?
A. Correct.
Q. And is it an idea of FPI or is it an idea of the United Pharmacist Network?
A. No. It's the idea of FPI.
Q. Okay. Is there a computer program that's called the Safe Provider Program?
A. It's a -- the Safe Provider Program is a credentialing program. It's very similar to -- are you familiar with the term "IPA," Independent Practice Association?
Q. Why don't you explain what that is on the record if you want to do that.
A. IPA would be a contracting group of health care providers. It's commonly used in managed care and it commonly in the past has been used for a group of physicians. This is quite analagous to an IPA with pharmacies and we -- FPI is part of the credentialing process that is ongoing within the network to give the buyer, in this case the Medi-Cal HMOs in California, the confidence that the network has -- is -- is

screened for and monitored in an ongoing way for fraud -- fraudulent activities.
Q. You mentioned the Medi-Cal HMOs would be the buyers. Do you have any Medi-Cal HMOs that are buyers of this product?
A. There -- there are several accounts they are competing for, UPNI, but currently, no.
Q. All right. And the -- I guess I didn't understand when you -- you mentioned that this is a credentialing program. Is there -- is there some software that FPI has developed that's part of --
A. No.
Q. No.
A. The program is an inspection by an investigator filling out a paper-based questionnaire. That questionnaire then is scored and a risk -- a risk factor is assigned to each individual pharmacy and those with high risk scores are then monitored more closely.
Q. Okay. And I assume from your prior answers that none of these inspections by investigators filling out these questionnaires and assigning risk factors is actually taking place

yet?
A. We are now in the phase of educating the network as to what the program is going to be. So there's a series of programs for the 70 pharmacies to bring their people in and Alan Cates is giving them talks on what the program consists of and what we're looking for. It's more of an educational process.
Q. So the answer to my question is no, you haven't begun any of these investigations?
A. We haven't started any investigations, correct.
Q. Okay. Now, are you actually yourself, sir, familiar with the investigations that have been -- that have taken place to date by the Medi-Cal Fraud Prevention Bureau?
A. I'm somewhat familiar.
Q. Okay. Just from reading the newspapers?
A. No. I've actually gone out on some investigations with -- with the investigators.
Q. All right. And do any of those investigations that you're familiar with, personally familiar with, involve pharmaceutical

manufacturers?
A. The investigation that I went out on involved medical supplies.
Q. Okay. And so the answer is no, it doesn't involve pharmaceutical --
A. Not --
Q. -- manufacturers?
A. My visit did not.
Q. Okay. And -- and you mentioned before how the Medi-Cal Fraud Prevention Bureau has -- has successfully undertaken prosecutions of physicians and pharmacists; correct?
A. Correct.
Q. Are you familiar with any Medi-Cal fraud investigation that involves the pharmaceutical industry?
A. The short answer is no.
Q. All right. And does any of your work in connection with FPI involve negotiating contracts with pharmaceutical manufacturers?
A. No.
Q. Negotiating with PBMs?
A. No.
Q. Negotiating with HMOs?

A. No.
Q. Has it given you any more familiarity with rebates, pharmaceutical rebates?
A. It's given me -- it's given me a more in-depth street knowledge of how -- of the effects of rebates on the market.
Q. How so?
A. It's a -- again, this is a big subject.
There are a number of activities at the pharmacy level in particular where fraudulent players have learned how to game the system. The system consists of obtaining external sources for evidence, and our investigators will look at the books for a vendor, say a durable goods company, a medical transportation company, a pharmacy, and they will determine what the -- what the -- what the vendor says that they sold and billed for and then we will go back to the supplier and determine whether or not the wholesaler actually delivered the product to the vendor. We will then go to the patients who received the supply and determine whether or not the patient actually received it.
Am I going off course here for you?

Q. What you're doing -- based on what you said before, you're using "we." Okay. None of the things that you just described actually involve you; correct?
A. Well, except for this one investigation that I was involved in --
Q. Okay.
A. -- that's correct.
Q. Well, then explain for me that investigation so I understand completely what that -- what that involved.
A. This -- this followed pretty much what I've just told you. We -- it was a durable goods company.
Q. What was the name of the company?
A. As I recall, it was called the Golden Supply Company or something like that. It was in San Francisco. And it mostly consisted of -- it was durable goods, which is where the -- where the highest percentage of fraud occurs within the Medi-Cal program. And this happened to be a business that served for the most part the Russian immigrant community in San Francisco, and we were involved in an investigation where you

looked at -- the investigators. I was not part of this. They looked at the -- at the company initially, and out of that process a high risk score was attached to the -- to the vendor, and then I came back in with the investigator and spent a day. We looked at the books of the vendor and his bank statements. We then went and visited with some of the patients who were -- who had received the supplies. We had previous -- the investigator had previously authenticated with the wholesaler that they had, in fact, delivered inventory.
Q. What was the product?
A. Well, durable goods are usually things like oxygen supply for patients at home, wheelchairs. Interestingly enough, the most frequent area of fraud in Medi-Cal is adult diapers.
So determining that, in fact, these supplies have been delivered to this -- this company by the wholesaler was one of the steps.
And then we went to the physician, who was one of the more prominent prescribers, and asked, Did you prescribe these entities? The way

the process works is the most common source for fraud in -- in the Medi-Cal or in any aspect of medicine is identity theft, so that supplies are billed to a person who does -- isn't aware that they are occurring or physicians are reported to have prescribed drugs that they didn't prescribe.

So you're looking throughout the system for evidence of identity theft as the start of the criminal investigation under -- under the Fraud Prevention Bureau.

Q. How much time did you spend on this one investigation you're talking about?

A. I spent a day and a half.

Q. Have you done any other investigations?

A. No.

Q. The pharmacists that you have signed up as part of the United Pharmacist Network, you mentioned tried to do some auditing to prevent fraud, those -- those types of things.

Is there a problem with fraud in your experience at -- at the pharmacy level?

A. Yes. Would you like that quantitated?

Q. Yes, sir.

A. Fraud in health care overall is about 10 percent. About 10 percent of all transactions in health care are by FBI figures siphoned off into fraudulent activity. The incidence of fraud at the pharmacy level can run somewhere north of 40 percent and the incidence of fraud in durable goods can run up to 90 percent of the transactions are fraudulent.

Q. Did -- have you had any -- have you had any discussions with any of the -- with any of the folks that are -- that are pharmacies that are plaintiffs in this case about the fraudulent activity that you're talking about?

A. I'm sorry.

Q. Have you had -- for example, are you aware of any fraudulent situations that involve CVS and Rite Aid, for example --

A. Oh, no, not at all.

Q. -- Mr. Einhorn's clients? Okay. Are you --

A. CVS -- CVS for the most part is not a California company. Rite Aid is. But generally speaking, these are not involving the chains.

Q. All right. So these are --

A. Fraud does occur at chains, but it's a different kind. This is more of a street crime type level crime.

Q. What's the fraud that occurs in the chain that you're become familiar with?

A. Well, it usually is complex litigation involving reimbursement rules for Medicare. I'm not personally familiar with it other than what I'd read in the paper. That's not our area of expertise.

Q. Okay. All right. The second group that you've become involved in since your last deposition is something called Illumination Medical, Inc., which in your report on Pages 5 and 6 you state that you currently own a privately held company --

A. Did you want this back?

Q. No. That will be one of the exhibits.

A. Should from now when I'm finished give this to the reporter?

Q. We'll just have a stack right here.

A. Okay.

Q. That's fine. Even this one, too. Your report you'll probably --

A. Sorry to step on your lines. I've broken my -- my goal already.

Q. Okay. The Illumination Medical, Inc. You state in your report that you currently own a privately held company, Illumination Medical, Inc. The company specializes in data mining. Illumination Medical analyzes medical and pharmacy claims to predict serious chronic illness in a population of beneficiaries before the disease process becomes catastrophic."

How much of your time do you spend on Illumination Medical, sir?

A. I'd say I spend about 60 -- 60 percent of my time, roughly.

Q. Do you -- in your resume, you state that you're the partner and chief operating officer since -- from 2003 to the present?

A. Correct.

Q. Do you have any other employees?

A. No. Just my partner and I.

Q. Who's your partner?

A. Her name is Lillie DuVale,

D-u-V-a-l-e.

Q. And --

A. Capital V.

Q. Is this -- is this still in the startup phase?

A. It is. But we have clients. I'm not sure when startup goes to not. We aren't drawing much in the way of money from it yet. So I guess it's startup.

Q. Okay. And can you tell us more what -- what you mean by saying that your company specializes in -- in data mining?

A. This is a very -- this is a -- this is a very important area within health care today.

For the most part, all of the techniques that we've used in the past to try to control medical costs, including prior authorizations and authorizations for referrals and authorizations for hospitalizations and the whole list as it goes on, has not worked. And the payers in the system, the insurance companies, the employers, have had self-funded trusts called ERISA, E-R-I-S-A, trusts, and the labor unions that have Taft-Hartley trusts, T-a-f-t-

H-e-a-r-t-l-y trusts, are now looking at a different approach, and that approach is to build off the realization that 1 percent of any beneficiary pool produces most of the cost. And there's an interesting finding, the 5 percent who have chronic illnesses that will likely lead to high cost and being able to intervene before they do so.

And that's what our company does. We work as a consultant to consultants. We put all of the medical and pharmacy claims data into a data warehouse and then we model that data to be able to predict who's going to get sick and who's likely to have catastrophic complications.

Q. And when you say you try to figure out who's going to get sick and who will have catastrophic complications, do you do that on an individual person basis or you try to look at certain -- certain groups, like an actuary, I guess I'm thinking?

A. Well, an actuary looks backwards. We look forwards. That -- that's the big difference between us and actuaries.

What I've described to you sounds

more complex than it really is. The reality is most of the cost in health care can be identified as occurring within a small group of people that are sick, people with congestive heart failure, people with asthma, people with hypertension. So if you can identify within a population of beneficiaries all those individuals who carry that diagnosis and then bounce the care that those people are receiving off of national recognized standards, for instance, how do you treat congestive heart failure as indicated by the American Heart Association, and when you find that people who carry these diagnoses are not receiving therapy within those guidelines, that becomes a target for intervention.

Q. How do you go about identifying what is the small group of people that are likely to get sick?

A. I put the population through a series of filters on the computer. I look at total cost that they've generated in the past. And in general I'm looking for not people that generate a hundred thousand dollars in the past year, but around 10,000. I look at their -- what

drugs they're receiving and by class identify whether or not there are drugs that are likely, that -- that -- instances where generics are more appropriate than brand. I look at the -- what are call HEDIS criteria, that's H-E-D-I-S, and it's -- it stands for Health Employer Data Information Sets.

And these are criteria that employers use to rate one health plan as opposed to another for quality.

So there are all sorts of criteria that you can look at, including whether children are getting immunized, women are getting Pap smears and mammograms. I look for instances within chronic disease. For instance, we just completed an analysis, and I look at all the patients within a plan that have atrial fibrillation, which is a condition of -- where the heart beats irregularly. And I will then look to see whether or not those patients are on anticoagulants. That's important, because an irregular heartbeat precipates blood clots in the heart that break away and then produce strokes or emboli to the kidneys or to some other -- produce

some other catastrophic complication.

So I look for all of the patients, all of the beneficiaries in the plan who carry diagnosis of atrial fibrillation who are not on anticoagulants, and of those who are on anticoagulants, are they getting blood-clotting studies done on at least a monthly basis. Now, I don't know the results of the blood-clotting study. I just know that the health plan paid for the test.

Likewise, I'll look at congestive heart failure. The national standards for therapy are that these patients are on ACE inhibitors, A-C-E inhibitors, and beta blockers. If they're not, the recidivism rate for visits to the emergency room are exceedingly high. And sudden death as well.

Q. Aren't there confidentiality concerns in connection with employers sharing that information?

A. There are absolutely -- the issue is known as HIPAA, which is H-I-P-P-A, which is the Health Insurance Portability Act, also known as the Kennedy-Kassebaum Act, and within the

structure of that we function as a business associate for the plan. So the plan creates a confidentiality structure and we function within their umbrella as a subcontracting business associate. That's well recognized within HIPAA.

Q. Okay. How many plans have you done this type of analysis for?

A. We've done two thus far. We have several more on the way. Our -- our focus is generally on plans that are 10,000 or so. Usually -- our first two was a multistate employer for supplying electrical products and the second was a union in California. We have several other unions that we anticipate bringing aboard and we have a -- we also market heavily into ERISA trusts that would typically be school districts or hospitals.

Q. Sir, in the instances where you've -- the two instances where you've made this type of analysis, I assume you prepare a report?

A. I do.

Q. And then there's a proposed plan of intervention for those folks --

A. There is.

Q. -- that are high risk?

A. Go ahead.

Q. Here's my question. How do you know that the employers, in fact, intervene by giving them, let's say, the medical care as opposed to working them towards termination or something like that?

A. Oh. I don't know how the plan would administrate. That would be --

Q. Be wrong; right?

A. Almost -- I can't imagine that they would use it for that nefarious purpose, the reason being that most of these are long-term employer arrangements. Certainly the Taft-Hartleys wouldn't be an option with the unions.

Q. Does -- does any of this work that you've done with -- with Medical Imaging, does that involve negotiating contracts with pharmaceutical manufacturers?

A. No.

Q. Negotiating with PBMs?

A. No.

Q. Negotiating with HMOs?

A. No.

Q. Rebates, exclusive contracts, anything like that?

A. No.

Q. Oh, I'm sorry. The name of the company is Medical Illumination.

A. Illumination.

Q. You -- you knew what I meant.

A. I do.

Q. I'm sorry.

A. Illumination Medical.

Q. Okay. How do you divide your time currently between the Fraud Prevention Institute, Medical -- I'm sorry, Illumination Medical and PCN?

A. I function at PCN as a part-time medical director, which is about 20 percent of my time.

Q. Do you have an office there?

A. I have a cubicle.

Q. Do you have a staff of any kind?

A. No. I -- my area of responsibility at the company is primarily the pharmacy and therapeutics committee and the quality assurance activities, and there are staffs for those

committees, but I really don't manage those staffs. And the one other area that I am involved in in the company is we --we have a program called Med Intelligence, which if you went out on the Web and pulled it off, you probably are aware of, and it gives counsel to physicians as to the medications that patients are on and it -- those communications are letter based and all the letters that go out are over my signature. And the staff for that activity, also I don't manage that staff.

Q. Okay. Why would a -- why would PCN sent out letters under -- as part of Med Intelligence to physicians?

A. There's a lot that goes on in the life of a patient that doctors don't know about. For instance, patients are seen by multiple doctors and are prescribed medications by multiple doctors and frequently a doctor isn't aware that a patient is taking a certain drug that would interact with a drug that he may have prescribed.

Likewise, one of the biggest problems in health care is noncompliance on the part of the patient, such that the doctor gives a

patient a prescription and for whatever reason the patient doesn't get it filled at the pharmacy. And so our ability to communicate to the prescribing physician that his patients, say, with congestive heart failures didn't get their prescriptions for ACE inhibitors filled is very helpful to that doctor.

Q. Do you also send out letters, sir, to physicians where they prescribe a product that is not on the PCN formulary?

A. That's infrequent, because just about every drug is on the formulary. It may be at the third tier. But those types of restrictive, almost enforcement activity that I'm sure we'll talk at about at length today is not something we generally do much of.

Q. How frequently have you sent letters like that for -- to physicians where they prescribe a product that's off formulary?

A. Well, again, the only -- most everything is taken care of at the -- at the dispensing site with the pharmacy. As I mentioned, third tier for our formularies encompass just about all drugs.

Q. Okay. I'm just -- I'm just trying to get your best estimate as to whether or not --

A. Hardly any.

Q. Hardly any? Once, twice?

A. The total number of letters sent out each month are in the thousands and -- high end thousands. And if we sent out two or three for that, I'd be surprised.

Q. But they'd be under your signature?

A. Yes, but the signature is automated, so I don't see every single letter that goes out.

Q. Okay. But you are -- you are aware of the fact that PCN does send out letters for products when a physician does prescribe a product that's off formulary; correct?

A. Again, I don't want to be absolute, but I'm just saying it's virtually -- it's not common. The most common thing that the letters involve is are you aware that this patient has another drug that they're on that the literature would indicate is contraindicated for this patient to be taking.

Q. Doctor, I'm not trying to figure out what the most common is. I want to get your

understanding --

A. Yes.

Q. -- as to whether or not you're aware that letters are sent out to physicians that prescribe products that are off formulary under your signature.

MR. COHEN: Objection. Asked and answered.

A. Again, I'm sure if we went through the whole list, we could find some of those letters. It -- it doesn't leap to my mind that we do it. I can't recall instances where it has happened, but I'm sure that occasionally you have it.

BY MR. DOBIE:

Q. Okay. How often does the P&T committee meet at PCN since -- let me back up.

At the time you had your deposition in June of 2002, the P&T committee had not met. Since June of 2002 --

A. Right.

Q. That's correct. Since June of 2002, has the PCN P&T committee met?

A. Yes.

Q. On how many occasions?
A. We meet -- we've been meeting now for about a year and we meet roughly on a quarterly basis.
Q. So since the beginning of '03, you've been meeting?
A. Yes.
Q. And you've had how many meetings?
A. We've --
Q. Four or five?
A. I'd say we've had about four or five meetings.
Q. Who are the other members of the P&T committee at PCN?
A. There's about seven or so members. It consists of both pharmacists and -- academic pharmacists and physicians.
Q. Are any of the staff folks at PCN that you mentioned members of the PCN P&T committee?
A. They're not members. I'm the only member of the committee. They -- they serve a support function for it, frequently research the drugs and make presentations to the committee.

Q. I'm sorry. I thought you said there were seven members of the committee.
A. There are.
Q. Okay. Then you -- did you say you're the only member?
A. I'm the only one from PCN.
Q. I understand. Okay. So there's -- you're the only member from PCN and the other six members are academic --
A. Are external.
Q. Understood. And why is the committee organized in that -- in that fashion? Why don't you have the staff members as -- as members of the P&T committee?
A. That's a good question. I think a lot of it has to do with tradition. If you -- if you study the history of formularies, they started as -- in hospitals. This was back in the '50s. And it was where the hospital determined it couldn't stock every drug. So there was a limited number of drugs in the pharmacy and they instituted P&T committees consisting of members of the medical staff that would consult as to what drugs were in the -- in the formulary for the

hospital and it's pretty much stayed that way to the present. It's nice to have outside physicians and pharmacists looking in on this process.
Q. How many -- how many -- of the six other members, how many are physicians?
A. All but one.
Q. Okay. So you've got -- you've got five physicians. Are any of them OB-GYNs?
A. One.
Q. Who is that?
A. Victor Chen, C-h-e-n, is an OB-GYN physician in Sacramento who's also a professor at UC Davis.
Q. Are any of them primary care physicians, the other four?
A. One is an emergency room physician. I'm just -- I'll work my way through the list here.
One is an endocrinologist. One is a rheumatologist. One is a pediatrician. I think the pediatrician probably would be the primary care. And then, of course, the internists with subspecialties also function as primary care.
Q. There's one internist?

A. Well, no. The rheumatologist --
Q. Oh, the rheumatologist.
A. -- the endocrinologist, and -- and you could classify the emergency room physician as a primary care physician.
Q. All right. So the -- you have these meetings, four or five meetings a year. How much of your time, if you were to divide it up between the P&T committee and the QA group and Med Intelligence that we talked about -- how would you say your time is roughly divided between those three groups?
A. I'd say about a third, a third, and a third would be rough.
Q. And since you have actually had the P&T committee up and running, has PCN created its own formulary?
A. We have.
Q. And when did PCN create its own formulary?
A. When the P&T committee was formed. That was part of the process for us to bring the -- bring the formulary back inhouse.
Q. All right. So that would have been

the beginning of 2000 --
A. Early -- early --
Q. Let me finish, if I could. The beginning of 2003?
A. Correct.
Q. All right. And as -- as part of the creation of a formulary, did members of the P&T committee meet with any pharmaceutical manufacturers?
A. The P&T committee does not meet with pharmaceutical manufacturers.
Q. And why not?
A. It's just not part of the process. We -- we meet -- let me explain the meeting.
The meeting is in a virtual environment, so people are in attendance from all over the country but nobody's in Sacramento. We work off of conference calls and websites. And the staff will make a presentation generally concerning four new drugs and we will hear a presentation of the scientific information available on the drug and then at the end make a decision as to whether -- as to what category the drug's going to fall in.

Q. Okay. So how about you yourself; as medical director of PCN, have you met with medical manufacturers as part of your responsibility on the P&T committee?
A. Occasionally I will attend a presentation by a pharmacy manufacturer on one of their new products as it comes through. It -- it's more for me a lunch meeting that -- that is primarily for the consulting pharmacists within the company and I will just sit in on it occasionally.
Q. These -- these are people that are detailing new products; right?
A. They're detailing new products.
Q. Okay. But have you met with -- with pharmaceutical manufacturers in connection with the establishment of the PCN formulary?
A. No.
Q. All right. How about the -- tell me more about what the -- what the QA, quality assurance, group does at PCN.
A. When -- when a health plan contracts out for the management of their pharmacy benefit, the contracted entity has to conform to the

quality assurance criteria for the health plan for the health plan to be able to be certified by the NCQA. That's the National Committee for Quality Assurance. This is certification that this independent group gives. It's kind of like the Good Housekeeping Seal of Approval. And we have to function within the guide -- this is a rather complex infrastructure, but we have to function within the quality guidelines for the health plan so we don't jeopardize their status with the NCQA.
So we run a continuous monitoring on all of the activities of the PBM to determine things like how long people have to wait when they call in on a phone or how long a delay might exist for a special request from a prescribing physician or if we have downtime on our computer systems, how much is it per month. Those sorts of things are the ongoing monitoring of the quality of the service that we provide as a PBM and then it feeds directly into the NCQA documentation for the various health plans that are our clients.
Q. So you have to -- PCN, which is a pharmacy benefit administrator, has to be

certified by the NCQA in order for people's health plans and things to use it, basically?
A. Two corrections. First, PCN is a PBM. It's a pharmacy benefit manager. It's just the title within health care. And no, we are not certified by NCQA. The health plan is. We have to conform to the health plan's quality criteria on management systems or we could jeopardize the health plan's NCQA certification.
It's very analogous to the issue we discussed earlier dealing with HIPAA. PCN is is not HIPAA qualified. It functions as a business associate to the health plans that are the HIPAA compliance entity.
Q. So there's -- there's certain standards that you as the PBM have to meet in order for the health plan to be certified by the NCQA?
A. That's correct.
Q. All right. And -- and you mentioned how long somebody waits on the phone and things like that.
A. Correct.
Q. Are there -- are there standards for

this that are -- that are promulgated by the NCQA?
A. The NCQA -- and you can go out and look at this. It's a complex process. But they establish all these various criteria that they want you to look at to -- so that you're monitoring for quality within how you administer a plan or how people get health care delivered to them and so forth.
And the process is not so much meeting a test score like you have in school. You know, if you get 90 or better, you get an A -- or 95 and better, you get an A and 85 and up, you get a B. It's not that way. It is whatever your -- you look at your performance based on your initial evaluation and then they want to see you close the loop. That means they -- that you recognize if there's a problem, you create a plan, and then you monitor to see if the plan improved performance.
Q. Dr. Gibson, to go back to my question, are there written standards the NCQA promulgates that you as the PBM try to live by?
A. There are criteria published and we function within those criteria and monitor our performance based on them.

Q. Do the -- do the criteria cover all subjects like the creation of a formulary?
A. No.
Q. The payment of rebates to plans?
A. No.
Q. How you handle things like prior authorizations?
A. If we have prior authorizations, how long does it take to grant them would be a criteria that would be applied.
Q. And what's -- what's the standard or the criteria that you're trying to meet as it relates to prior authorization in order to meet the NCQA standard?
A. Generally they try to turn around prior authorization in a short period of time during business hours. I don't know exactly, but I'd say it's within 24 hours.
Q. Okay. Are there other examples like prior authorizations that you can think of that -- that you have to meet under the NCQA criteria?
A. Well, again, the criteria we're trying to meet is the criteria that the health plan sets for NCQA and another one would typically

be do we have downtime on our computers, which would affect the pharmacy's ability to receive hard and soft edits and things that we'll talk about later, I'm sure.
Q. Okay. Let's go on to another position that's mentioned in your report.
In your current report on your resume, you state that you've been the president of the Pacific Development Group from 2000 to the present; correct?
A. Correct.
Q. Okay. Now, the report that you filed in the Duramed case said that you were the president of the Pacific Development Group beginning in 1998.
Can you explain for me the reason for the difference?
A. No.
Q. Okay. When did the Pacific development group -- was that founded?
A. I started it roughly when I left Omni.
Q. But at the time of your last deposition, you said that you were spending half

of your time on the Pacific Development Group.
How much of your time are you spending on the Pacific Development Group now?
MR. COHEN: Today?
MR. DOBIE: Yes, sir.
A. I would say 10 percent of my time.
BY MR. DOBIE:
Q. And is it essentially consulting with physician groups and -- on business issues?
A. No. It's a very specialty-based consulting practice and it has evolved over the years.
Q. What is it doing currently?
A. What's it doing currently?
Q. Yes, sir.
A. I'm working with a group of pharmacists that are primarily based at USC in Los Angeles to explore the development of an infusion therapy network.
Q. And what's an infusion therapy network?
A. Health -- the nature of the pharmaceutical products is changing. We're going from pills that people take at home to drugs that

are -- with high potency that require injections. And your client has one of those products. It will be Enbrel. But these are products that require a clinical presence during administration.

Q. Okay. And -- and you said that you're working with the pharmacists at the USC, University of Southern California University?

A. Correct. Not -- not at it. These are mostly alumni and affiliated with the School of Pharmacy at USC.

Q. Okay. Does -- does the project have anything to do with the University of Southern California other than these are alumni?

A. It may. The project's evolving at the present time. It may bear the USC nameplate.

Q. So this is a -- this is a project that is --

A. It's a development project.

Q. And at this point, what are you trying to help the pharmacists do as it relates to, as you -- as you explain it, physicians having to have a more clinical presence during the administration of the pharmaceuticals? What's -- what's the interface between your client group,

the pharmacists, and what you've described before, which is the need to have doctors have -- have a -- I guess be more involved with the administration of pharmaceuticals?

A. I don't recall that I said that, but why don't I back up a little and maybe I can make this a little clearer.

Q. Sure.

A. Currently these specialty drugs, Enbrel being an example, are typically administered either in the doctor's office or in the emergency room. There are a lot of problems that are resulting from that current platform and the pharmacists are exploring the opportunity to create their own infusion therapy centers that are community based.

Q. So in essence, replace the doctors and have the pharmacists provide the infusion therapy?

A. Physicians could be present during the infusion process, but it has more to do with how product is distributed.

Q. Right. But is the idea essentially that you'd have the pharmacist be able to

distribute the product, assuming that there was a prescription from a physician, as opposed to having the physician give the product?

A. In essence, yes.

Q. Okay. At the time of your last report, you had still on your -- your resume that RxPhysician was from January of 1998 to the present.

Do I take it that RxPhysician currently is -- at least your involvement has ceased?

A. RxPhysician is inactive.

Q. There's -- there's a website that's out there now. It's still RxPhysician.

Do you have any involvement --

A. It's not --

Q. -- with that?

A. It's not ours. At least, I don't know about it.

Q. All right. It sells Viagra, weight loss drugs, things like that?

A. That's not us.

Q. That's not you. Okay.

With RxPhysician, we spent a fair

amount of time talking about it in your last deposition, so I don't want to repeat it. I just want to make sure I understand something, because we had some correspondence back and forth with -- with Mr. Cohen trying to make sure that we had an understanding of -- of some data issues.

First, am I correct that the data that you developed -- let me back up.

Tell us generally what RxPhysician -- what you were trying to do as it related to the PBA project for RxPhysician?

A. We were trying to develop a digital-based ordering system for prescribing medications for physicians in the clinical setting.

Q. Okay. And there was a study that was done in this clinic in Santa Barbara and a study that was done at the Straub Clinic in Hawaii; correct?

A. Correct.

Q. And in connection with that study, you developed certain, I think as you put it in your last deposition, anecdotal data. Do you recall that?

A. Correct.

Q. And that data was never formalized into a report; correct?
A. No. It was proprietary.
Q. And -- well, not only wasn't it -- let me make sure I'm being clear.
I understand it was proprietary, but you never prepared a report with that data either; correct?
A. Correct.
Q. And you don't have that data here today?
A. No, I do not.
Q. All right. And do you know who has the data?
A. I have the data.
Q. Oh, you do have the data?
A. It's in my head.
Q. Oh.
A. I know the outcome of those evaluations of physician work environments.
Q. All right. If somebody wanted to test the information, to look for themselves at the information that came from the study at the Straub Clinic in Hawaii or the Santa Barbara

Clinic, is there any source or any information by which someone could test that information?
A. No. Let me just back up.
I suppose you could talk to some of the physicians that were involved in the -- in the project, but that you -- you as an -- a dispassionate observer that would want to go and read about it, you -- you wouldn't. It's not published.
Q. Is there -- is there any other published literature that you're familiar with that has done a study like what you did at RxPhysician?
A. I think just about every one of the digital-based ordering companies did similar type studies to be able to develop their products.
Q. Okay. Did any of those -- talking about the digital-based ordering companies. Who are those companies?
A. Well, most of them now are defunct. But one was called IScribe. Another was called EPhysician. WebMD was -- at that time was called Healthion. That was a predecessor. They -- they merged into WebMD. Did a lot of work on digital

prescribing. And a number of the -- of the electronic medical records companies that wanted to add a digital ordering module to their product would have done those kind of studies.
Q. Potentially a big market.
A. The potential market was great. It was an incredible flop.
Q. Okay. None of these companies ever brought a product to market; correct?
A. No. Almost everybody brought a product to market. The issue wasn't having technology that worked or even technology that doctors would use. The problem was being able to make it -- the business model work.
Q. Okay. We -- we covered some of that in your last deposition, so I don't want -- I don't want to repeat all that.
The anecdotal information that you -- that you gathered, you mentioned last time that you hadn't done any sort of double blind study or as you said perfect science. How many physicians were in the study that -- that was done at the Santa Barbara Clinic?
A. We had about 10 to 15 physicians at

the Santa Barbara Clinic and a similar number at the Straub Clinic. And if I -- if may, let me just say that that was the second generation of our work. We did -- the first generation was in Sacramento, where we -- where we deployed our first effort, and then the round with Straub and the Santa Barbara Clinic was the second round.
Q. What was the -- you didn't tell me about that in your last dep, I don't believe. What was the clinic in Sacramento?
A. It wasn't a clinic. This was in individual physician offices. We were dealing -- and I won't go into great detail here, unless you want me to, but the first generation of this was with wide-area network infrastructure for the handheld PDA devices, and that consisted of using cellular phone technology to link the handheld device to -- to the system.
We -- that was -- that was not -- we determined that that technology was not going to work because there's a lot of -- if you have a cell phone, you know that there's a lot of black holes with cell phones, where they just won't work. And that was what we discovered.

So in the Santa Barbara Clinic and in the Straub Clinic, we deployed with a local-area network which was wireless, and that consisted of communication to a server within the clinic using wireless connectivity within the clinic itself.

Q. How many physicians were in the Sacramento study?

A. About 10 to 15. I don't recall the exact number. Mostly primary care.

Q. And in Santa Barbara with the -- with the product, did you have any sort of a lead physician that you were working through?

A. We worked with the department of ambulatory care, and I'd say I worked with all the docs down there. I spent a fair amount of time in Santa Barbara and I would spend time in their offices. I spent time with their nurses. I spent time with the pharmacists that received the communications. And through that I got a feel for how the flow of a practice works, how much time was spent on the prescribing part of the practice and how we could improve that using electronic data.

Q. The department of ambulatory care that you mentioned --

A. It was -- the community medicine department was its exact name.

Q. And did you have a contract with the community medicine department?

A. No, we didn't have a contract. They permitted us to come in and use the technology, in that they were interested it as well. They were -- they were intrigued by whether this would improve the practice within their clinic.

Q. Who was your primary contact in that facility?

A. Well, let's see. The CEO of the clinic at that time -- I have to go back in my records. But we worked through the clinic administration, the CEO of the clinic and the chief operating officer of the clinic and the chief information officer of the clinic, because we were installing information technology.

Q. So when -- so when you went in to pitch the RxPhysician.com product, the pitch was in essence to the administrators?

A. Correct. And let me correct you on

one item there.

It wasn't the pitch to sell a product to them. We provided all of the technology, all the software, all the support, free. This was -- our -- our interest was to see if we could develop a system that they'd actually use and it would help in their practice.

Q. How long did the project go on at the --

A. For about two months.

Q. Right.

A. Six weeks to two months.

Q. And at the end of the two months, did the administrators ask you for a report of any kind?

A. No.

Q. They just said, Okay. We've been using your technology. You've taken our time --

A. We collectively determined that it wasn't ready for show time.

Q. Okay. And when you say "collectively," did that include the administrators at the community medical --

A. Yes.

Q. -- group?

A. Yes. It was -- it was apparent to everyone involved that this -- this -- rather than improving productivity, it decreased productivity for the physician and there was not any financial benefit to the physician that resulted from that inhibition -- or that reduction in productivity.

Q. All right. And then the Straub Clinic in Hawaii. Was that again a similar-type deal where you would talk to the administrators in --

A. Right.

Q. -- the first instance? Who -- who were the administrators of the Straub Clinic that you were dealing with?

A. I'm sorry. I'd have -- I'd have to go back in -- in my records on that. But we were -- we were more -- we were multilocation with Straub instead of one location at the Santa Barbara Clinic. We -- we were -- Straub is -- has clinical facilities throughout all of Hawaii. So all five islands they have clinical facilities. And we were involved in -- we were -- we were -- we were mainly in the Honolulu area. But we -- we

had -- we deployed in three or four different clinical settings and all of it was on the local-area network infrastructure. And there was a broader spread of the background of the physicians involved. We had pediatricians, we had family physicians, we had some specialists in internal medicine --

Q. How about --

A. -- as I recall, endocrinology.

Q. How about OB-GYN? I'm sorry.

A. I think we might have had one OB-GYN doc.

Q. Do you recall that or --

A. I don't recall clearly. But I recall we visited with the OB-GYN department and I believe we had one doc that came up on the system.

Q. Okay. And then similar result with the Straub Clinic in Hawaii as in Santa Barbara?

A. As far as the outcome?

Q. Yes, sir.

A. Correct.

Q. And did the Straub Clinic in Hawaii ever ask you for a report in terms of --

A. No.

Q. Let me finish. -- how the -- how the project had gone?

A. No.

Let me just say one other thing on that. Hawaii is an interesting place. It's not like --

Q. For many reasons.

A. Yes. And it tends to have monopolies and the insurance company -- health insurance company over there that's -- that dominates Hawaii is called HMSA, which is really the Blue Cross plan, and they elected to go with a contract with a company called All Scripts that was exploring digital prescribing. And so it -- not only did we not feel that our technology was ready for deploying. We -- we would then have had to compete heads up with All Scripts and HMSA and we just -- it was apparent that we should pull the plug.

Q. Did -- did All Scripts -- is that something that was owned by HMSA?

A. No. All Scripts is a company -- it's publicly traded. It's out of Illinois, close to your home base, and I think they lost their

shirt on this project in Hawaii.

Q. Do you know whether or not All Scripts ever put the project in place with more than one -- let's say 10 or 15 physicians?

A. It's my understanding they did and they did it with -- with a contract with HMSA, and I think it was a performance-based contract. So that if the physicians would use it, they would get paid. And I don't believe -- I'm not privy to any of the details of how it went. I just have heard.

Q. Well, did you hear the physicians didn't use it and so they didn't get paid?

A. I heard that it was deployed and the equipment was delivered, but the actual number of scripts that went through the system were disappointing.

Q. The process or the project that you did at the Straub Clinic in Hawaii, how many weeks did that go on?

A. Oh, that was a couple of months.

Q. And in the process of the -- of it going on, tell me what kind of -- and this is true for Santa Barbara. You don't even need to

distinguish between Santa Barbara or Hawaii.

What would be the -- generally speaking, how would the data flow from the physicians to make it back to you and your -- your partner at RxPhysician.com?

A. Well, all the transactions went through a server and we were online with that server.

Q. Okay. So you could -- you could see through -- through monitoring the server what physicians were doing?

A. Correct.

Q. All right. I think I understand why -- so it's not like physicians are filling out surveys of how they like it or things like that?

A. No. We were -- we were real time. And the real essence was we roughly knew how many scripts the docs were writing every day. We knew roughly what they were writing for. Because that's how we loaded up the system. We didn't load it up with every drug that had an NDC code. And we could monitor percentage of usage based on that.

Q. Okay. And what -- generally

speaking, what was the percentage usage in the -- in the Straub Clinic in Hawaii?

A. It varied by doctor depending on how committed they were to the whole idea. Some people didn't use it at all. Some used for half of their prescriptions. It never really rose to the level of clinical acceptance. If you're going to run an electronic system and you're going to store records and you're going to have information, you pretty much have to -- everybody has to use it all the time. Same is true with electronic medical records. You can't opt in and opt out or you get these gaping holes in your database.

So we never got even close to what I -- what I would call acceptable utilization rates.

Q. Okay. Do you -- do you remember offhand whether the doctor that was the OB-GYN was the doctor that never used it at all versus used it half the time?

A. My memory is foggy here, but my -- my best estimate would be that if we included him, he didn't use it.

Q. On the Santa Barbara Clinic, do you know whether or not -- let me back up.

With the Santa Barbara Clinic, is that a similar experience in terms of some doctors using half the time, some not at all?

A. Yes. These systems are real touchy and, you know, not only does it take more time to order a script than to write one, but electronic systems don't always work. So it was -- if you didn't have a physician who was really committed to this, the aggravation that resulted from it would turn them off.

Q. Okay. Omni Health Care. We can jump over there for a minute. You were the vice president, medical affairs, and chief medical officer from May of 1996 through January of 1998; correct?

A. I don't know the month, but it would have been '96 to '98. It would have been a couple of years.

MR. DOBIE: Let us just mark this as the next exhibit.

* * *

(Whereupon, Gibson Exhibit 4 was

marked for identification.)

* * *

BY MR. DOBIE:

Q. I hand you what we marked as Exhibit 4. Dr. Gibson, do you recognize Exhibit 4?

A. Do I -- I'm sorry?

Q. Do you recognize Exhibit 4?

A. Yes.

Q. This is -- this is the report that you prepared in the Duramed versus Wyeth case?

A. I would -- I believe that's accurate.

Q. Okay. In the -- in your CV that's attached thereto, you've got the time period Omni Health Care as May of '96 to June of '98. Does that refresh your recollection that that was the time?

A. It helps, yes. Thank you.

Are we done with this?

Q. Not quite. Not quite.

In this resume, you state, and this is on Page 14 -- we're talking about Omni. You state that "As the VP, medical affairs, I also chaired the pharmacy and therapeutics committee

for the health plan." Do you see that? The very last line.

A. I see that.

Q. Okay. Now, in your -- your current resume that we've attached to -- or you've attached to your report at Exhibit 1, you have a description of Omni Health Care and you've deleted that sentence as having been the head of the P&T committee at Omni Health Care. I'm wondering why that -- why was that sentence deleted.

A. It was an inadvertent editorial.

Q. In which way?

A. It didn't have any -- it didn't have any bearing to experience or change. It's just what I included as my responsibilities.

Q. Okay. And so as it relates to -- the resume that's attached to your current report, that's the accurate situation?

A. I chaired --

MR. COHEN: Objection to the form.

A. -- the committee.

BY MR. DOBIE:

Q. Oh, you did chair the committee?

A. I did chair the committee. I

just -- I didn't happen to write it in this report.

Q. Oh, I see.

A. Or in this CV. I did a lot of things and you just pick and select what you put in it. This CV that you have here is generally used when I'm involved in a consulting engagement and --

Q. Which one for the record?

A. The one that is in the current report. And to chair a P&T committee for a lay reader, it doesn't have a lot of meaning for most people. It does within this context, but it wouldn't, say, with the owner of a business who wanted to engage Illumination Medical.

Q. Well, sir, you picked the resume to attach to your report; correct?

A. Correct.

Q. Okay. And did you think it was relevant whether you did or didn't serve as the chairman of the P&T committee at Omni Health Care?

MR. COHEN: Objection.

Argumentative.

A. I think it's relevant. If I were to

redo it, I would have included it. I did, however, include it at the front of the report that I chaired it.

BY MR. DOBIE:

Q. Actually, your report says that you have been the CEO of three different HMOs. That's on Page 5 on your background. And looking through the resume, and I tried to add them up and count them up, I didn't come up with you being the CEO of three different HMOs.

What are the three different HMOs that you were the CEO of?

A. I was the CEO of the Sisters of Charity Health Plan in Houston. I was the CEO of the Tallahassee Physicians Association Health Plan in Tallahassee, Florida.

Q. I'm sorry. The Sisters of Charity --

A. In Houston.

Q. In Houston. And then what's the one in Tallahassee?

A. It would have been the Tallahassee Physicians Association Health Plan.

Q. Okay.

A. And I was the CEO of the Samaritan Health Plan in Phoenix.

Q. When were you the -- let's look at your -- your report here. Maybe you've got the dates.

A. Could we go back to one item? You had a question about whether or not --

Q. Yes, sir.

A. This issue of the P&T committee.

If you'll look on Page 5 under the heading "Background," first paragraph, you'll see the last sentence --

Q. Oh, I see it.

A. Okay?

Q. When were you -- when were you the CEO of the Sisters of Charity Health Plan?

A. That was when I was at the -- these were all activities involved with my ownership of Avanti Health Plan. Avanti -- or not Avanti -- Avanti Health Systems. Avanti was a medical development company and we developed all of those health plans from scratch, moved them through to licensure. I functioned as the CEO of the health plan during its startup and we would ultimately

replace ourselves with recruited full-time staff.

Q. So where it says here Avanti Health Health Systems, says 1984 through 1991, your -- your service as the CEO of the Sisters of Charity Health Plan in Houston would have been at what time period between 1984 and 1991?

A. That would have been early, so it would have been roughly '84, '85. It was -- our first client -- our first client in Texas was the Baylor Health System, and my partner, whose name is -- was Marty Dale, is -- his name, Marty Dale, was responsible for that project and he served as the CEO of the Baylor Health Plan in Dallas. And our second client was the Sisters of Charity in Houston and I took responsibility for that account.

Q. Okay. And -- and tell me more about what the Sisters of Charity Health Plan -- what that was.

A. It was a Catholic health system consisting of a number of hospitals distributed around the United States but most of them in Texas. The primary area was Houston. But they stretched over to Beaumont, down to San Antonio,

and as I recall, there was one or two hospitals up in northern Texas around the panhandle.

Q. Okay. But the Catholic health system hospitals, I mean, that's been around forever. What -- tell me, explain for me what you did in terms of the creation of the Sisters of Charity Health Plan as it -- and how that fits within the Catholic health system.

A. Okay. We're going to get into a little lesson here about Catholics.

Q. I've got plenty of them at home.

A. The Catholic hospitals in the United States are not one entity. They are owned and managed by various orders of sisters. The Sisters of Charity -- their full name was the Sisters of Charity of the Incarnate Word. Their -- their base was in Houston. And they started their first hospital, as most Catholics did, during the great flu epidemic of -- I think it was 1912 and people were dying like crazy, and basically they created a place for people to die with dignity. And from that they grew into a multibillion dollar corporation and had hospitals distributed around.

When the HMO movement came into

health care, you will recall that prior to, oh, 1980, back during the Nixon years, the majority of health care was paid for by indemnity health insurance, where you would see a physician or a hospital, you would pay for the service, and then you would be reimbursed by the insurance company after you had met a deductible.

We -- there was a massive move in the market to first dollar coverage or these health plans at about that time, and the Sisters of Charity, like many other hospitals, were interested in forming their own insurance company. So it would be essentially an inhouse underwriter of their services.

This came out of people admiring Kaiser and the concept was a three-legged stool, wherein Kaiser had their own hospitals, their own medical group, and their insurance company, and many of the larger hospital systems in the America were experimenting with that model. And we were one of the major developers that could come in and develop that for them.

Q. I mean, what your resume says is that you were a development and management firm,

Avanti Health Systems.

A. That's right.

Q. Okay. It's kind of a very broad description. I'm just -- I'm trying to understand when you talk about helping them and now you mention Kaiser -- you know, did they -- did you end up setting up a Kaiser-type shop for the Sisters of Charity Health Plan?

A. I mentioned Kaiser in the context of this three-legged stool concept and hospitals and their physicians were exploring a Kaiser-like entity that could compete in the prepaid market.

Q. All right. And is that what the Sisters of Charity Health Plan was?

A. It was the -- one of the legs of the stool.

Q. All right. Explain that for us, if you will.

A. We were the insurance company.

Q. All right. So you developed an insurance company for the Sisters of Charity?

A. Correct.

Q. For this particular hospital in Houston?

A. No. For their system.

Q. Systemwide?

A. Right.

Q. And then you did the same thing for the Tallahassee Physicians Health Plan?

A. That was -- that was -- yes, that was formed by the physicians in Tallahassee that were in independent practice and they contracted with us to form a health plan, which we were able to take through development to licensure by the state and ultimately federal licensure.

Q. And so each of these is -- and then the Samaritan Health Plan in --

A. Phoenix.

Q. In Phoenix. Same thing. You're basically creating a health plan?

A. Correct.

Q. All right. And these are just like if -- if you have a company with 10,000 people. You're describing four. They may create a health plan. They might have consultants that advise them in connection with the creation of a particular health plan. You mentioned before the ERISA plans, the Taft-Hartley-type structures,

those are the types of health plans that you're -- that you -- that you created when you were at Avanti Health Systems?

A. No.

Q. All right. Explain that for me.

A. The products that we developed at Omni would be --

Q. Omni or Avanti?

A. Avanti. Sorry.

Were two types. One was an HMO which was licensed by the state and federal licensure. And it was a -- it -- it delivered first -- first dollar products that would be HMO products.

The second type of an insurance company we would create in tandem with that was an indemnity insurance company that would stand behind PPO products. That would be -- stands for preferred provider organizations.

Q. Okay. And the Sisters of Charity Health Plan, as you mentioned before, was an insurance company?

A. The Sisters of Charity -- we formed two companies for them. One was the Sisters of

Charity Health Plan and the other was the Sisters of Charity Indemnity Insurance Company, I believe.

Q. Okay. So you're -- you're helping them form this company. It -- after forming it, did you play a role in connection with the management of it?

A. We did.

Q. For how long?

A. We developed the company and my staff staffed the company until we recruited and handed over to full-time -- full-time employees of the health plan. So I would serve as the CEO. My director of marketing served as the director of marketing. My network developer would develop the physician networks.

Q. All right. And for how long did you serve as the CEO of the Sisters of Charity Health Plan?

A. For about a year.

Q. How long did you serve as the CEO of the Tallahassee Physicians Health Plan?

A. About six months.

Q. And how long did you serve as the CEO of the Samaritan Health Plan in Phoenix?

A. I'd say around six months.

Q. And --

A. Maybe a little longer for the last. It could have been 12 months.

Q. Okay. And with each of those three plans, was -- was the pharmacy benefit carved out?

A. The pharmacy benefit for the most part really didn't exist in -- in its current iteration until the early portion of 1990.

Q. So is the answer yes, the pharmacy benefit was carved out?

A. Well, the pharmacy benefit was for the most part a discount card.

Q. Okay.

A. So that -- that doesn't technically fit the term "carved out." It was an add-on supplement that the purchaser could buy, but for the most part they were not insurance products. They were in many ways quite similar to what is coming out of Medicare now.

Q. Okay. And I've asked you some other questions about Avanti that I don't believe I need to repeat.

You said you read your deposition on

the way out. Was there anything in that deposition that you felt the need to correct?

A. I read -- I just glanced over it on the plane coming out here. In general, I think it's fine. I'm sure there will be minor things that we'll go over as we spend the day, but nothing --

Q. Was that the first time you read it?

A. I read it one other time after I -- you and I visited in Sacramento, because I had to sign the deposition. But those are the two times I've read it.

Q. Right. And when you signed it, you didn't have any -- any corrections to the substance?

A. I wouldn't have signed it if I did.

Q. Okay.

MR. COHEN: Gordon, are we at a time to take a little break?

MR. DOBIE: Sure. It's been a couple hours.

THE WITNESS: Sounds good to me.

THE VIDEOGRAPHER: This is the end of Tape No. 1. The time is 12:02 p.m.

We're now off the record.

* * *

(Whereupon, a short recess was taken.)

* * *

THE VIDEOGRAPHER: This is the beginning of Tape No. 2. The time is 12:20. We're back on the record.

BY MR. DOBIE:

Q. Dr. Gibson, I want to ask you a little bit more about your -- your resume that you attached to your report.

You mentioned in here some of your certifications. Are you a member of any professional associations?

A. I'm a member of the California Medical Association.

Q. Anything else?

A. Not now.

Q. Have you ever been a member of the -- have you ever been a member of the American Pharmaceutical Association?

A. No.

Q. Have you ever been a member of the

California Pharmaceutical Association?

A. I'm not a member. I -- if you'll recall, the California Pharmaceutical Association owns PCN, and I work very closely with the California Pharmacists Association primarily as a consultant.

Q. Right. But are you a member of the California --

A. No.

Q. -- Pharmaceutical Association?

Are you a member of the American Managed Care Pharmacy Association?

A. No.

Q. Are you a member of the National Association of Chain Drugstores?

A. No.

Q. Are you a member of the National Council of Prescription Drug Programs?

A. No.

Q. Are you a member of the pharmacy advisory committee for the California Medi-Cal?

A. No.

Q. Do you serve on any advisory panels with any pharmaceutical manufacturers?

A. No.

Q. Do you serve on any industry advisory panels with any -- or for any PBMs?

A. No.

Q. Publications are listed in Attachment B to your bibliography, the last 10 years. It looks like the last article that you wrote involved fraud in health care, and this is an article that discusses how fraud is a serious problem that physicians are involved in in health care in California; correct?

A. Well, the article discusses the issue of fraud in health care, and physicians being part of the system, it discusses that, yes.

Q. Okay.

A. It didn't base its discussion that physicians were the cause of fraud particularly.

Q. No. But the focus of the article is physician fraud; correct?

A. No. The focus of the article was fraud in health care.

* * *

(Whereupon, Gibson Exhibit 5 was marked for identification.)

* * *

BY MR. DOBIE:

Q. I show you what we marked as Exhibit 5. Sir, for the record, Exhibit 5 is a copy of the article that we're just discussing, "Fraud in Health Care," that you published in February of '04; correct?

A. Correct.

Q. And this is -- the Sierra Sacramento Valley Medical Society has a newsletter that you -- you edit; correct?

A. It's not a newsletter. It's a -- it's a newspaper --

Q. Okay.

A. -- or a magazine.

Q. A magazine?

A. A better way to put it. It's a magazine. And I serve on the editorial committee and I'm the associate editor of the magazine.

Q. And are any of the -- any of the articles -- let's start with this one. This is not a peer-reviewed article; correct?

A. Correct.

Q. And are any of the articles that are

on your CV peer-reviewed articles?
A. No, these are not peer-reviewed articles.
Q. Have you ever published anything that's been peer reviewed?
A. Many times, but it was earlier than 10 years ago. It would have been back when I was in academic positions at Harvard.
Q. All right. And the -- what are some of the subjects that you've published on --
A. My area --
Q. Let me finish. -- as it relates to peer-reviewed articles?
A. Most of them dealt with the area of immunogenetics. I was particularly interested in the genetic background of children who got arthritis, so I published in that area. I did HLA tissue typing.
Q. All right. And the -- have you ever published any peer-reviewed article in the -- in any -- have you ever published a peer-reviewed article that relates to managed care issues?
A. No, I have not and I've -- in general, those types of articles aren't peer

reviewed.
Q. And what are the -- what are the publications that you're familiar with that address managed care issues?
A. Oh, there are hundreds. It's approached either from the insurance industry perspective or from the pharmaceutical industry perspective or the medical physician perspective or the employer perspective.
Q. Okay. You said that most articles on managed care are not peer reviewed.
Have you seen, for example, articles that discuss topics like the impact of copays on prescribing habits and things like that?
A. Generally those types of articles are not peer reviewed. They -- they fall more into the category of what you have in front of you, which would be -- probably the best category would be op-ed type pieces or editorials, or they could include data, but they're not -- they're not -- they -- they'd all fall into the -- when I -- when I would publish for the New England Journal of Medicine, say, that was heavily peer reviewed by six or seven authorities in the field

before it would be published in the New England Journal of Medicine.
Q. Okay. So just answer my question then. You have not published any peer-reviewed article that relates to managed care issues; correct?
A. Correct.
Q. All right. We discussed in your last deposition your prior service as an expert witness in litigation. I think you told me that --
A. Are we done with this?
Q. Yes, sir. -- that the -- that the Duramed case was the first lawsuit that you'd -- that you'd been involved in; is that correct?
A. Correct.
Q. Have you been involved in any other litigation since the Duramed case?
A. The only other -- there -- there were two instances, which really weren't litigation. They could have been.
One was I was rear-ended on Interstate 80 and had a retired judge help me settle the case with the insurance company. That

was a matter of correspondence.
And the other was my daughter was involved in a rear-end collision and our insurance company worked with that.
Q. But in terms of you working as an expert in any litigation --
A. Oh, no.
Q. No. And your report indicates that you're being paid $300 per hour for research time and $500 an hour for testimony.
A. That's correct.
Q. And in the Duramed case, you were paid $300 an hour. Why the difference in your rates?
A. I've gotten better.
Q. All right. How have you gotten better?
A. I have more experience. You taught me a lot in the last round.
Q. All right. Did -- did you, sir -- I guess, why are you making the distinction between time that you're spending on testimony versus time that you're spending on research?
A. This is more difficult.

Q. Have you ever commanded $500 an hour before for any of the other projects that you've done?
A. My -- my fees in consulting generally run between 3 and 5 hundred dollars an hour.
Q. And what company --
A. Plus expenses.
Q. What company -- which of your companies have you charged clients 3 or 5 hundred dollars an hour for?
A. Well, we discussed UPNI earlier. I'm charging them 300 an hour.
Q. Who have you charged 500 an hour to?
A. The charges for that range would usually fall in the arena of retained fees or deliverables. So I'm not billing by the hour, but it works out to that.
Q. What -- what do you mean by "retained fees" or --
A. Well, for instance, Illumination Medical charges on a per employee per month basis, and those are based on deliverables. So we deliver a report quarterly to the client and they

pay monthly based on a per employee basis. So depending on how long it takes me to generate a report to the client is not based on hourly but the deliverable.
Q. Okay. Is anybody -- can you name any other company that's actually agreed to pay you $500 an hour?
A. No.
Q. Do you maintain time records that you spend in connection with this engagement?
A. I do.
Q. And how do you keep your time? What's -- what's your process in connection with this engagement?
A. I usually log in each day how much time I spend or if I spend nothing in a day, I don't log anything in. Keep it on an Excel spreadsheet and turn in a invoice every couple of weeks.
Q. And how much time have you spent in connection with your engagement in this case?
A. I'd say -- I don't have the records with me, but I'd say I've roughly spent about three weeks in aggregate. That's not three weeks

solid.
Q. But about 120 hours or so?
A. I'd say more than that. I would work -- when I -- when I'm billing, I work longer than an eight-hour day usually.
Q. That's why I gave you the 120.
A. Yes.
Q. What's the --
A. I'd say I'm more closer to 200 hours.
Q. 200 hours? So how much have you been paid so far in connection with this engagement?
A. Again, I don't have the records with me, but I'd say probably around $60,000 or so.
Q. So are you still owed $40,000 as you're sitting here today?
A. No. Mr. Cohen has been very good about reimbursing my invoices.
Q. Okay. Well -- all right. So it's -- I see. $300 an hour times the 200 hours is 60. Got it.
Okay. When were you retained to work on this J.B.D.L. case?

A. Let's see. As I recall, it was the latter part of last year.
Q. So late 2003?
A. Yes. I recall that Mr. Cohen contacted me and we met in Sacramento, and as I recall, it was latter part of 2 --204 -- 203.
Q. Okay. And what did Mr. Cohen tell you about the case when you met with him?
A. First he called and gave me a very high-level look that -- as to who the plaintiffs and the defendants were and roughly what the case was about and then asked if I'd be interested, and I said I would be interested in working on the case. And we scheduled an opportunity to have lunch together in Sacramento and we walked around the grounds of the capitol and visited and talked about it.
Q. What did he -- what did he -- tell me what he said about his case, about the case that was on file.
A. He said that this was a suit between your client, Wyeth, as the defendant, and a class of -- of individuals or businesses that consisted mostly of the -- of most of the distribution

chain -- chains, the distribution system within the pharmaceutical industry in the United States. That would include most of the wholesalers and most of the retailers with the exception of Rite Aid and CVS.

Q. All right. And what did you -- when he described the case, what did you say in response?

A. I said that it looked interesting and that I would be interested in working with him as an expert witness on it.

Q. Now, did you -- did you have some understanding as to what area you were going to be asked to be an expert in?

A. I did.

Q. And what was your understanding of what area you were going to be asked to be an expert in?

A. My responsibility was to be able to describe and explain how the health care system works, how it works in its broad perspective, including both the medical and the pharmaceutical distribution systems, how their -- how money flows through those systems, and how those systems can

and were influenced.

Q. Go back and look at what we marked today as -- as Gibson Exhibit 4, if you would, sir.

A. Me?

Q. Yes, sir. You got your report as 1. And there's your report there.

A. Okay.

Q. All right. And on the second page of this report, you state that you were asked to prepare a report in order to provide an expert's perspective on how restrictions of formulary listings by major managed care organizations affect the prescribing behavior of physicians. "Specifically I will analyze the consequences of Cenestin being excluded from substantially all major managed care formularies from Cenestin's market introduction in 1999 to the present." Do you see that? Right at the top.

A. Yes. Okay. Yes, I do see that.

Q. All right. And in your current report, you state that you are now going to give an expert opinion that extends -- this is on Page 6 of your current report. In your current report

on Page 6, you have a broader description of what you've been asked to do. You state that you were asked to prepare a report in order to provide an expert perspective on how Wyeth accomplished its anticompetitive objective using exclusive dealing and market share incentive-based contracts within the health care systems. You were going to analyze the cumulative effect of this successful marketing strategy and how it influenced the decision making by American physicians as they selected estrogen products in their patient and that your report will analyze the consequences of Cenestin being excluded as a result of Wyeth successfully executing marketing strategy from substantially all major managed care formularies for Cenestin's market introduction in 1999 to the present. Do you see that?

A. Yes.

Q. Why the broader scope of this report?

A. This was what I was asked to -- to evaluate and report on.

Q. Weren't you asked to do the same thing in the Duramed case and you suggested that

Mr. Susman would be better served by having Mr. Bystrom play that role?

MR. COHEN: Object to the form.

A. I -- with -- on the Susman case, I did recommend that the Susman firm bring in Mr. Bystrom to comment on and report on the dispensing side of the aisle and I kept the prescribing side.

* * *

(Whereupon, Gibson Exhibit 6 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Let me show you what's been marked as Bystrom Exhibit 6. I'm sorry, Gibson Exhibit 6. For the record, Exhibit 6 is a copy of the Bystrom deposition that was taken on July 18th, 2002.

This is something that you reviewed before your last deposition; correct?

A. As I remember, I did read it.

Q. All right. And -- and if you turn to Page 218 of that deposition. It's towards the back.

A. Okay.

Q. You were asked a series of questions --
A. I was?
Q. Yes, sir. I'm sorry. Mr. Bystrom --
A. Bystrom.
Q. -- was asked a series of questions about his retention in this matter, and he was asked, "Did you and Mr. Gibson discuss your reports -- or Dr. Gibson discuss your reports with each other before they were submitted?
"ANSWER: We knew that we were both working on reports and that his was focused on the physician area and mine was focused on pharmacy and PBM."
Next question: "Did you have conversations with Dr. Gibson about the substance of your report?
"ANSWER: No, not necessarily.
"QUESTION: What sort of conversations did you have with Dr. Gibson about your report?
"ANSWER: We talked about the fact that originally he was the first person contacted

by Duramed through Susman to create a report that was inclusive of pharmacy and PBM information; and then he quickly realized that that's not where his expertise was and recommended they contact me for that. So then I told him that I would be working in that area, and those are the expert opinions that were rendered based on the things in those two weeks" and so on.
First let me ask you. Is -- is Mr. Bystrom correctly describing his conversation with you back in this time period?
A. He's pretty -- pretty accurate. There were -- there -- there's some additions to that that could be made.
Q. Is it -- is it a true statement that you said to him that your area of expertise was not on the pharmacy and PBM side?
A. At that time, my statement to him was that I wanted him involved in the case to buttress that.
Q. Okay.
A. So it could -- it comes out this way.
Q. All right. I understand that you

asked him to do that. My question is different.
Did you say to him that it was not your area of expertise, that being pharmacy and PBM information?
A. Again, I was -- I was aware of rebates and how they worked. I did not feel that my area of expertise was as deep as his at that time and I felt it served the Susman firm better if they brought him in.
Q. And what do you mean by your area of knowledge wasn't as deep as his?
A. Well, Dale had started -- Mr. Bystrom had started a PBM himself. He started Longs Drugstores PBM that ultimately became RxAmerica. So he had many years of experience in the PBM industry, how -- how -- the minutiae of how things worked, and he had years of experience in the retail pharmacy. So he had worked with the information systems within the pharmacies and so forth, which I had not done.
Q. Given that, sir, why did you not also recommend Mr. Bystrom as an expert in this case?
A. I didn't -- I didn't have a say as

to who would be the consultants or the experts on this case, so I can only speculate on why Mr. Bystrom was not asked. My level of experience within the PBM environment and how the pharmacies actually work operationally changed considerably from this time to the present.
Q. All right. What do you mean that you didn't have a say? Did you recommend to Mr. Cohen or any of the other lawyers that they would be better served to have Mr. Bystrom as an additional expert in this case?
A. I asked Mr. Cohen if he was going to retain Mr. Bystrom and he said no.
Q. Did he say why not?
A. No. He indicated that he wanted me to cover these areas, and I left it at that. And I left it at that because I felt confident that I could do this job for him.
Q. We'll come back in a -- in a bit to your additional expertise and experience, but I want to go through some more questions as it relates to your retention before we get back to that.
A. Are we done with this?

Q. For the moment. It will -- it will be another -- you can put it in the stack there.

What materials have you reviewed to prepare to testify and provide a report in this case?

A. Well, certainly everything that was footnoted in my report was reviewed. I believe that Mr. Cohen delivered to you a list of articles that -- or not articles, but discovered documents that I had been given during the course of my evaluation, and then my general ongoing reading in both the lay and professional press.

* * *

(Whereupon, Gibson Exhibit 7 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Okay. For the record, Exhibit 7 is a copy of the document that you were just referring to, which is the e-mail from Mr. Cohen that describes additional materials that you reviewed.

And for the record, sir, are these -- does this list that's included in Exhibit

7, the third or fourth pages, together with the documents that are cited in your report, together with -- I think you said materials that were in the lay or professional press constitute the universe of information that you reviewed in issuing your -- preparing your report?

A. I would -- I would say so. This -- these last two pages are a series of -- what's the term that you have --

Q. Bates numbers?

A. Yes. So I'm not sure that, you know, for instance I saw WYE117064. I probably did. But this looks about right. I had several boxes of discovered documents.

Q. Okay.

MR. COHEN: I'm sorry to interrupt you, but just so the record is clear, and since this is my e-mail, Mrs. Ward asked -- Mrs. Ward asked me for this listing, and because of time factors, it's not -- it's not intended to be an all-inclusive list. So, in other words, it may be duplicative of what's cited and it may be on top of what's cited.

In addition, it does not include any of the documents that Dr. Gibson reviewed as part of his charge in the Duramed case. And, of course, all the documents he reviewed in the Duramed case are also documents that are part of the current case. So he brought that knowledge with him into the case.

So I apologize for interrupting your -- your line of questioning, but I just wanted to clarify that.

MR. DOBIE: Okay. That's -- that's perfectly fair and actually helpful.

THE WITNESS: Could I say just one other thing too on that?

BY MR. DOBIE:

Q. Yes.

A. And that is after the Duramed case I kept no documents. So I didn't keep a box or several boxes --

BY MR. DOBIE:

Q. So you -- you destroyed all the documents that you --

A. I sent them back to Susman.

Q. Okay. And so -- so you could -- whatever you could recall of the documents from the Duramed case, I guess that would form in part maybe some of your knowledge base that you're telling us about here today and that's in your report; correct?

A. Yes. I requested that the documents cited in my report and many of the documents cited in Dale -- Dale Bystrom's report be sent to me for review.

Q. Okay. So -- so you received those documents from counsel?

A. I did.

Q. All right. And then -- and then how did you go about selecting or deciding what else to look at?

A. I learned a great deal from the first round, and what I learned was the way to approach a complex subject like this is to start with your outline. So the first series of exchange of documents between me and Mr. Cohen dealt with creating the outline of what I was going to write about. So that went through several iterations. So I was focused on the

subject that I needed to cover. For instance, I'm not involved in the economics of the case. There's another expert that will be dealing with that. Or the pricing per se of drugs. So there was a give-and-take between us on what the outline would look like.

Once we got to a pretty complete outline of what I was going to write about, then I'd ask for his assistance in helping me find documents that related to the issues I was going to review. So it was through that process that I got my first pass at the documents that I would review.

And then there was a -- there was a document that came to light. I don't recall exactly how it came to light. But it was the contracting manual of Wyeth. And that produced in my mind a whole series of questions that I wanted to get more detail on. And so that -- that produced an interest in documents for me.

So I think that -- that pretty well explains how I wound up with the documents that I did have and how I used them in writing my report.

Q. Okay. Can I -- can I just sum up

then and make sure I have it?

In essence, you -- you asked for and received the documents that were cited in your last report and in Mr. Bystrom's report?

A. Right. Some of them. I didn't ask for all of them, but I did select ones I wanted.

Q. Okay. Second, you -- you had documents that were selected by Mr. Cohen as being helpful to whatever you guys were thinking about putting into the report based upon the outline?

A. Correct.

Q. Okay. And then -- and then as you mentioned before, there are documents that you may have -- or articles that you might have seen in the press?

A. No. The third thing I cited was the issue of the -- Wyeth's contracting manual that was in 1995.

Q. Okay. But that's -- I'd put that within the group of documents that Mr. Cohen brought to your attention.

A. Oh. I think that's how I -- I wouldn't have known about it otherwise.

Q. Okay.

A. I think that he brought that to my attention. And then after reviewing that, I had a lot of questions.

Q. Okay. So the -- so the -- again to sum up, do I have it all then? You've got --

A. Yes, I think you've got --

Q. -- the documents --

A. I think you've got it all.

Q. All right. Just so the record is clear.

We've got the documents that were cited that you wanted to have additional copies from either your last report or Mr. Bystrom's report; the documents that were selected by Mr. Cohen for you to review as part of the preparation of the outline, which then makes its way into the final report; and then last, documents that -- that you became interested in as a result of the contract resource manual being brought to your attention?

A. I think that sums it up, yes.

Q. All right. And the specific documents that you were interested in as a result of your review of the contract resource manual

were what, sir?

A. I was particularly interested in how -- in examples of how the Wyeth personnel included the verbiage from the contracting manual in the actual consummated contracts on the market.

Q. Sir, if you look back at Exhibit 7.

A. Sorry. I --

Q. That's the e-mail from Mr. Cohen.

A. Oh, okay. Yes. Okay.

Q. Do you have that in front of you?

A. I've got it here.

Q. And if you look at the list of documents, you don't mention Mr. Bystrom's report as one of the things that you reviewed. Why is that?

MR. COHEN: And again, Gordon, sorry to interrupt, but Dr. Gibson didn't prepare this. I prepared this and that would be my omission, not Dr. Gibson's.

MR. DOBIE: All right.

BY MR. DOBIE:

Q. So did you review this before this -- this was sent to us?

A. I -- these were inventories that

were -- accompanied the times when he sent me reports. So no, I didn't actually see it before it was sent off to you, but I recognize these as the documents that accompanied the reports.

Q. Okay. So -- so the process was when you got a -- you would get a series of documents from Mr. Cohen. Would you get a transmittal letter that said enclosed is --

A. Something like that, yes.

Q. With the Bates numbers?

A. Something like that or a covering index of within this box you will find these referenced document -- documents.

Q. All right. The -- and I see that there is -- in your entire report, I didn't see any documents that you cited that came from Duramed.

Is there some reason why you didn't cite any documents that came from Duramed?

A. In -- in my report that I turned in?

Q. Yes, sir.

A. I can't think of a particular reason why I didn't.

Q. And the --

MR. COHEN: I understand. I just misunderstood how -- how you were stating it. I'm sorry.

MR. DOBIE: All right.

BY MR. DOBIE:

Q. And did you, sir, have the opportunity to interview anybody from Duramed in connection with the preparation of your report?

A. No, I didn't.

Q. Did you interview anybody from Viking in connection with the preparation of your report?

A. No, I did not.

Q. Did you review -- interview anybody from Barr Labs in connection with the preparation of your report?

A. No.

Q. Did you interview anybody from Solvay in connection with the preparation of your report?

A. No.

Q. Did you interview anybody from Cardinal in connection with the preparation of your report?

A. This report ran for almost a hundred pages, so --

Q. Right. In the material that you reviewed, I only see five pages that referenced documents that came from Duramed.

Again, Mr. Cohen didn't send you any -- any additional documents that came from Duramed, to your recollection?

A. Not to my recollection.

MR. COHEN: I'm sorry, Gordon. I'm not sure that I understood what you just said.

Did you just say that there were five pages that referenced Duramed documents?

MR. DOBIE: Yes.

MR. COHEN: Because there's only one page that references any -- are you -- are you saying that there's five Duramed cites? Is that what you meant?

MR. DOBIE: Yes. If you look at --

MR. COHEN: Okay.

MR. DOBIE: You've got DUR35, DUR37, again 36 --

A. No.

Q. I assume you haven't spoken with anybody at Wyeth in connection with the preparation of your report?

A. You can assume that, yes.

Q. Did you speak with any witness in this case that has knowledge of the situation with Premarin and Duramed and the Cenestin product in connection with the preparation of your report?

A. Okay. Now, you're asking did I visit with any witness that was involved in the prior suit, not this one that we're here on?

Q. Yes, sir.

A. Well, I visited -- visited many times with Dale Bystrom.

Q. Okay. Anybody else?

A. No.

Q. Did you interview with any of the witnesses in the J.B.D.L. case?

A. No.

Q. Have you had any discussions with -- with a particular plaintiff in this case, the J.B.D.L. Pharmacy?

A. No.

Q. Have you had any discussions with anybody from the Q Pharmacy?
A. No.
Q. Have you been retained by the indirect purchasers class action as well?
A. No. I'm not sure what that one is.
Q. All right. So Mr. Cohen is the -- in his group, which is the direct purchasers, the large wholesalers and retailers, they're the ones that have retained you in connection with this matter?
A. Correct.
MR. COHEN: And CVS and Rite Aid.
MR. DOBIE: That was my next question.
BY MR. DOBIE:
Q. Have you -- have you been retained by CVS and Rite Aid?
A. It's understanding that I have been.
Q. Okay. When did that occur?
A. I would have to defer on that. I don't know. I've been working with Mr. Cohen, and I understand that -- that Rite Aid and CVS is one of the parties -- or is sharing the cost involved

in this case, but I -- until -- really until I came for this -- this deposition, I was not fully aware of that.
Q. Had you met Mr. Einhorn before today?
A. No, I had not.
Q. And have you ever had any discussion with Mr. Einhorn or anybody else representing CVS or Rite Aid before today?
A. No.
Q. How much did you -- did you come in yesterday in connection with this -- with this deposition?
A. I came in on Sunday night.
Q. Sunday night. Did you meet with Mr. Cohen?
A. I did.
Q. And when did you first meet with him in connection with the preparation for the deposition?
A. I met with him yesterday morning at 9 o'clock.
Q. And when did you finish your meeting with Mr. Cohen?

A. Around 2:00 in the afternoon.
Q. What did you talk about in that meeting?
A. Mainly I went over our deposition -- my report with him. I reviewed the components of it. We talked about what was likely to come up as that document was reviewed today. I think it was just a matter of -- of my being able to really focus on the document and go back to what the case was all about so I understood exactly what I was testifying -- how my testimony fit in here.
Q. What did he say about how your testimony would fit in here?
A. He reiterated what my responsibility was, my area of responsibility. He indicated that when I didn't know something, I should say I don't know it. He indicated that I didn't -- unless you wanted to talk about it, that I really wasn't responsible for discussing the broader economic pictures or the -- how drugs got priced.
So it was more of a review of what I was responsible for, what I wasn't responsible for, and again he reiterated that I should try to be brief in my answers, which I'm not sure I'm

doing very well with.
Q. Is -- your report, you don't discuss how -- how either Premarin or Cenestin were priced; correct?
A. I know generally how they were -- and what they -- what they were on the market for, but I have no knowledge of what was -- what went on behind the scenes as to how the companies priced them.
Q. You haven't reached any conclusions or opinions as it relates to what impact any of the activities or things that you talk about in this report would have on the price of either Premarin or Cenestin, have you?
A. I do have opinion.
Q. But it's not in your report, is it?
A. No.
Q. Right. And -- and do you intend to offer that opinion at trial if you haven't put it in your report?
A. I suppose if you ask.
Q. Did you -- is there some reason why you didn't put it in your report?
A. Well, again, it was -- I think there

are people that can speak to that with much more eloquence and experience than I have.

Q. All right. You -- you also mention Mr. Cohen said there's certain areas that might get focused on today.

What did he say in that regard?

A. I can't recall. I think -- I think we discussed how the review of the contracts that I included would be a matter of discussion. I think that there was a -- there was a give-and-take on the documentation relating to time flow studies for physicians. I believe that we -- let's see.

I think we reviewed in general the evolution of managed care, which was covered in the report. We talked again a bit about drug formularies and copayment structures and so forth.

In general, I think we went through the table of contents and looked at -- looked at the report and just kind of generally chit-chatted back and forth about what I've written and that -- you know, that these were going to be issues for questions.

Q. Who wrote your expert report, sir?

A. I did.

Q. Every word?

A. I pulled some of the verbiage from Dale Bystrom's report and footnoted it accordingly.

And I would like to make a bit of a comment about that.

Dale Bystrom and I worked throughout most of the drafts of the Duramed documents as a team. We were in the same room, particularly down in Houston, at Susman's law firm, where we had access to all of the documents. And we would -- we would routinely trade text. We would -- we would routinely trade portions of the text back and forth between -- between ourselves. It was fairly late in the preparation of the final drafts that we actually demarcated where my report would end and his would begin.

Q. Sir, I'm a little confused. Did -- did you work on part of Mr. Bystrom's report in the last instance? Is that what you're saying?

A. What I'm saying is that there was a report that was generated by both of us that towards the end of the editing process was split

into two portions. And what you saw as the finished product was what Dale had and what you had as the finished product was mine. However, a lot of the actual text in Dale's was written by me and a lot of the text in mine was written by Dale.

Q. And let me ask you this, sir: You mentioned that the -- where you had taken from Mr. Bystrom, you had footnoted that in -- in your expert report in this case.

If you turn to Exhibit 1 in this case just as an example, your 12th page of your report, the page you have right in front of you --

A. Yes. What page number?

Q. Page 12. I think you had it right in front of you there. Okay.

Didn't you essentially just simply cut and paste this from Mr. Bystrom's report and now put it into yours?

A. I cut and pasted this from Mr. Schondelmeyer's slide preparation.

Q. You're talking about the chart?

A. Yes.

Q. Okay. So the chart was cut and pasted from Schondelmeyer. How about the text

that's up above and below it; that's all taken from Mr. Bystrom, isn't it?

A. It could have been. I don't -- I don't recall if it was or not, but it could have been.

Q. And you haven't attributed any of this to Mr. Bystrom, have you?

A. I attribute -- there's one -- there's one reference -- particularly when we get back into the area of NDC blocks and soft edits and hard edits, I put a reference to that. See, that would have been --

Q. That's on Page 44.

A. Is that where it is? So you see the footnote there.

But I didn't -- I was asking if he'd seen Footnote 51, which he had. But I didn't -- I didn't footnote every section of the text that I used from his report.

Q. Actually, what the footnote says, sir, is that "Many of the definitions used in this section," and 51 refers -- there's a section here that's called "Retail Vendors" -- "were developed in collaboration with Dale Bystrom when we worked

together on the Duramed" -- and has the cite case. You see that?

A. I do.

Q. Where in this report do you say that you're actually quoting or -- or basically taking wholesale Mr. Bystrom's entire discussion on a particular area and putting it into your report?

MR. COHEN: Object to the form.

A. I don't have any other footnotes from Mr. Bystrom than the one that's referenced.

BY MR. DOBIE:

Q. Why do you say that it -- it says, "Many of the definitions used in this section were developed in collaboration with Dale Bystrom." Why didn't you say most of the section relating to the pharmaceutical distribution system, pharmacy benefit managers, et cetera, all came from Dale Bystrom's report and I simply put it into my report?

MR. COHEN: Object to the form.

A. I didn't -- it didn't occur to me to do it. I could have done that. However, the way you describe it wouldn't have been the way I'd have footnoted it. I could have put in that

segments of this report were in Dale Bystrom's final report and that many or most of those areas were areas that I coworked with him on when he was developing his report.

BY MR. DOBIE:

Q. Okay.

A. So it didn't seem to me that it was the same thing as citing a document that I was merely reading and didn't have any involvement in.

Q. Well, which of the -- which of the sections that are in here that didn't come from Mr. Bystrom did Mr. Bystrom also work on?

A. Could you repeat that?

MR. COHEN: Objection.

BY MR. DOBIE:

Q. You said that both of you worked collaboratively on one document.

Okay. So my question for you is, are there sections in -- in your report that Mr. Bystrom also worked on?

MR. COHEN: Object to the form.

A. Yes, there were. And he was able to interface with my report on the dispensing pharmacy interrelationship with the physician

during the prescribing process.

BY MR. DOBIE:

Q. Why did you say on Page 44, 51 -- on Foot -- Footnote 51 that it's just many of the definitions used were developed in collaboration with Dale Bystrom?

MR. COHEN: Object to --

BY MR. DOBIE:

Q. Why did you limit it to "definitions used"?

MR. COHEN: Object to the form. Asked and answered.

THE WITNESS: Say again.

MR. COHEN: You can go ahead.

A. The business that Dale Bystrom brought to his report that were really unique to his report and I had little collaboration in were these definitions. You know, the business about the NDC, the hard edits, the soft edits. Those were his -- those were areas that he had a great deal of experience in.

MR. DOBIE: Why don't we go ahead and mark Dale Bystrom's report as Exhibit 8.

* * *

(Whereupon, Gibson Exhibit 8 was marked for identification.)

* * *

BY MR. DOBIE:

Q. I hand you for the record what was marked as Exhibit 8. Okay. And if you -- first, is this the Dale Bystrom report that you're referring to?

A. I assume that this is his final report in the -- in the Duramed case.

Q. And is it your testimony that you wrote part of this report, sir?

A. It is my -- my statement that I collaborated on big portions of this report.

Q. All right. And if Mr. Bystrom -- Mr. Bystrom testified that he wrote the entire report himself, would that be a lie?

A. No. He did write the report, but he didn't say that he didn't have any input from anybody else.

Q. Okay. But I'm talking about the actual verbiage, the words that are here in this report. Is it accurate to say that Mr. Bystrom wrote these words or did you write the words?

MR. COHEN: Objection. Asked and answered.

A. Every -- every portion of the final report he wrote. That's what he turned in. Every portion of what I turned in I wrote.

BY MR. DOBIE:

Q. Okay. So --

A. And if I could just say, in this report, everything that I wrote I wrote. Now, I might have left in it the verbiage from Mr. Bystrom's report, but it would only have survived my editing.

Q. All right. Well, let's look, for example, at Page 12 of your report.

A. Of --

Q. Your report, Exhibit 1. You keep that handy. Look at Page 12 of your report.

A. My report. Okay.

Q. Keep Mr. Bystrom's report handy as well.

All right. Now, in your report, you say -- at the top, you've got the pharmaceutical distribution system; correct?

A. Correct.

Q. All right. And then if you turn to Mr. Bystrom's report, at Page 5, he also has -- at the top, it says the pharmaceutical distribution system; right?

A. Right.

Q. And then you've added -- in your report, you've got a paren that says "wholesalers, mail order, and retail sales." You've added a first sentence that you wrote and then the rest of the paragraph you just lifted directly from the -- Bystrom's report, which you said he would have wrote the language that appeared in his final report; correct?

MR. COHEN: Object to the form.

A. Correct.

BY MR. DOBIE:

Q. And you didn't put a citation here for Mr. Bystrom, did you?

A. No.

Q. And you don't put it in quotes, do you?

A. No.

Q. And if you go to the paragraph right behind -- right below the graph that you took from

Mr. Schondelmeyer, that's also from Mr. Bystrom, the next two paragraphs as well; correct?

A. Correct.

MR. COHEN: Objection.

BY MR. DOBIE:

Q. And again no quotation to Mr. -- to Mr. Bystrom or citation to him; correct?

A. Correct.

Q. And if we go to the bottom of the page under the pharmaceutical payment system, where it says "Payment Cycle for Pharmaceuticals," that too was lifted from Mr. Bystrom; correct?

A. Portion of it was. He didn't have the graphic --

Q. The graph you took from Mr. Schondelmeyer; correct?

A. Correct.

Q. Right. And then if we go on to the -- to the next page, 13, that all comes from Mr. Bystrom as well, doesn't it?

A. Could you -- would you like me to --

Q. Well, let's go -- go to the first paragraph here, Page 13. "Pharmacy patients can be divided into two categories" and so on. That's

from Mr. Bystrom on Page -- Page 5? It's the second paragraph.

A. Page 5, the second paragraph.

Q. So if you're looking at Mr. Bystrom's report on Page 5, under the payment cylce for pharmaceuticals, the second paragraph where it says, "Pharmacy patients can be divded into two categories"?

A. Yes.

Q. Okay. So you took that paragraph from Mr. Bystrom's report?

MR. COHEN: Object to the form.

A. Correct.

BY MR. DOBIE:

Q. Right. And then the next paragraph where it says, "The payment cycle for pharmaceuticals begins at the pharmacy with patient and/or patient health plan," that too came from Mr. Bystrom's report; correct?

A. Correct.

Q. And if we go through the pages again, there's -- there's page after page that's just lifted directly from Mr. Bystrom's report --

MR. COHEN: Object --

BY MR. DOBIE:
Q. -- without any quotation or attribution to him; correct?
MR. COHEN: Object to the form.
A. Correct.
THE VIDEOGRAPHER: Stand by.
(Pause.)
THE VIDEOGRAPHER: Proceed.
BY MR. DOBIE:
Q. Is there any other work that you believe is necessary for you to do, sir, to form an opinion on the issues that you've been asked to render an opinion on?
A. Is there any --
Q. Is there other work that you need to do in order to form an opinion on any of the issues on which you've been asked to render an opinion?
MR. COHEN: Object to the form.
A. I believe that I have completed the work necessary to -- to back up the report that I turned in.
BY MR. DOBIE:
Q. All right. Is there any -- does the

report represent a complete statement and the basis and the reasons for your opinion?
A. Yes.
Q. And is there any other work that you feel you need to do in order to feel confident about the opinions and conclusions that are set forth in your report?
A. No.
MR. DOBIE: It's 1:15. You guys want to take a -- try to do a quick lunch today?
MR. COHEN: Yes.
THE VIDEOGRAPHER: We're going off the record. The time is 1:20 p.m.
* * *
(Whereupon, a luncheon recess was taken.)
* * *

* * *
AFTERNOON SESSION
* * *
(Whereupon, Gibson Exhibit 9 was marked for identification.)
* * *
THE VIDEOGRAPHER: We're back on the record. The time is 2:03 p.m.
BY MR. DOBIE:
Q. Dr. Gibson, in -- in preparing your report, you mentioned the outline process that you had gone through towards working on the final.
Do you have copies of any of those outlines?
MR. COHEN: Could I just interpose, Gordon, I think the agreement in the case is that we're not going to be exploring drafts or any of that type of thing.
MR. DOBIE: Let's -- let's go off the record just for a second.
THE VIDEOGRAPHER: We're going off the record. The time is 2:03 p.m.
* * *
(Whereupon, a discussion was held

off the record.)
* * *
THE VIDEOGRAPHER: We're back on the record, 2:05 p.m.
BY MR. DOBIE:
Q. Dr. Gibson, I'm not sure whether you have drafts or not. What -- what counsel is telling me is that there's apparently an agreement in place that the parties aren't going to take or try to get copies of each other's drafts and things like that.
I assume that this is -- though, is something that you did prepare on your computer; correct?
A. Correct.
Q. Okay. And worked out over the course of some time period?
A. Correct.
Q. And in addition to the things that we covered before we broke for lunch, let me show you the next document that I marked in this series. This is Gibson Exhibit 9, and for the record, have you ever seen this before?
A. Was this the -- was this the

reference document that I gave you in the -- as footnoted in my report?

Q. I believe that you did cite this in your report, yes, sir.

A. Then I saw this.

Q. Okay. You reviewed this?

A. The main reason I went out and sought this information was to be able to identify AIS.

Q. And what is AIS, for the record?

A. It's primarily a publisher of -- it's a company that -- that writes articles and publishes them in business-like periodicals. And, for instance, they issued here Managed Care Weekly and -- oh, and Managed Care Weekly.

Q. And if you turn to your report, which is Exhibit 1, and go to Page 16.

A. Okay.

Q. You actually have simply just lifted wholesale from this document and put it into your report; correct?

MR. COHEN: Object to the form.

A. The -- let's see. We're -- we're on Page 16?

BY MR. DOBIE:

Q. Yes. So if you start at the bottom under "Effect on Employers."

A. I see. Okay.

Q. Starting with the second sentence, "As companies put the finishing touches on 2004 employer benefit design changes," those two paragraphs are set forth in your expert report on the bottom of Page 16 running over to 17; correct?

A. Right. They were getting back to the article on managing direct costs in Managed Care Weekly.

Q. Okay. And again, why did you not -- why didn't you put quotations that you had actually just quoted this directly from -- from the managed drug cost article here on pharmacy benefit management?

A. I thought my footnoting was adequate.

Q. Okay. Is it -- your normal practice is if --

A. Yes.

Q. -- something's written in the New England Journal of Medicine that you -- if you

were going to just quote articles, that you would attribute the language to the actual author of the article?

MR. COHEN: Objection. Argumentative.

A. Not necessarily -- I would not necessarily quote the exact -- if I -- if I put a quote in, it's -- if I put a footnote in, it's where I'm getting the material, but I don't necessarily always put quotations around it.

BY MR. DOBIE:

Q. You don't?

A. No.

Q. All right. And so throughout this report, do you know how much of this report actually has your language and how much of it has language that came from another source?

MR. COHEN: Object to the form.

A. I'd say most of it is my own writing. I have used sources similar to this and what we discussed earlier. Most of my opinion or all of my opinion is my own writing.

BY MR. DOBIE:

Q. Do you think that as much as 50

percent of your report was simply lifted from other sources and then moved into your report?

MR. COHEN: Object to the form.

A. I don't -- I'm sorry. When I -- when I used other material, I usually footnoted it. This article particularly dealing with factual material is heavily footnoted. Whether I pulled the material and paraphrased it or used directly out of the article, I'm -- I'm not prepared to say what percentage.

BY MR. DOBIE:

Q. Okay. Well, you're the one who prepared your report. Do you remember what your process was for doing it?

A. I -- if -- if the material agreed with what I wanted to say, I might use that and I generally footnote it.

Q. Okay. Again without -- without --

A. Without quotations.

Q. Without quotation marks. So, for example, the next two paragraphs of your report as well as on Page 17, "The most common plan design changes for 2004," that's -- again, if you look at the second page of Exhibit 9, that's the same

language that's in your report; correct?
A. Which is what I wanted to say.
Q. And if you go down to the -- let's see, two more paragraphs in the article where it says, "Employers generally are more aggressive" --
A. Uh-huh.
Q. -- than are health insurers in pushing" -- right. There what you've done is you've edited out the fact that that was actually a quote from AdvancePCS's CEO, David Halbert; correct?
A. Yes.
Q. All right. So this is a quote from the chief executive officer of AdvancePCS and you've removed that and then just put that in your -- in your report; correct?
A. Correct.
Q. All right. And then the next paragraph that starts, "Employers are now" -- "generally are more aggressive," that's again word for word taken from this article with the exception that you removed the fact that that again came from Mr. Halbert, the chief executive officer of AdvancePCS; correct?

A. Correct.
MR. COHEN: Object to the form.
BY MR. DOBIE:
Q. Now, when you remove or use language that's like this, what effort did you make, sir, to check the information that's contained in -- in the article?
MR. COHEN: You're referring to Exhibit 9?
MR. DOBIE: Yes, sir.
BY MR. DOBIE:
Q. So the article says, for example, "As companies put their" -- "the finishing touches on 2004 employee benefit design changes, they are stepping up adoption of time-tested approaches to slow spending on prescription drugs - and are evaluating a few new strategies."
What -- what did you do to confirm the accuracy of the statement that's in this -- this article that you've quoted from?
A. That's -- that -- any time I quoted something like that or use material from something like that, if it -- if it was consistent with my experience in operational environment within a

PBM, I didn't go further. And this is completely consistent with what I hear on a daily basis within PCN environment.
Likewise, I could add just one other piece. It's very consistent with information I get from working with the consultants in the marketplace and with the ERISA trust and Taft-Hartley trust that we're working with with Illumination.
Q. Okay. But go to the -- go to the next paragraph there. It says, "Techniques like mandatory mail order fulfillment requirements and a four-tier pharmacy design have been around for a few years but used by a minority of payers." Do you see that?
A. I do.
Q. Okay. How would you know, sir, whether it was used by a minority or a majority of payers other than from taking it from this article?
A. If you'll go ahead and look at the documentation in the balance of the report, you'll see the actual percentage numbers that relate to tiers and copayments drawn from authoritative

industry sources.
Q. Okay. But those -- again, those are -- those are other materials that you have taken from other industry sources and just put into your report; correct?
A. I used other industry sources in my report to buttress issues of fact.
Q. Okay. But, I mean, just an example, if you look at your report and you go to -- let's just -- let's just use one as an example. Page -- Page 13 we were looking at before, the chart that's there.
A. Uh-huh.
Q. Okay. You as an expert, sir, have put into your report -- you've got the source of payments for prescription drugs 1999. This is -- this is something that you have taken from another study and again placed it into your report; correct?
A. Correct.
Q. All right. But you don't know, for example, whether in 1999 28 percent of prescription drugs were purchased through chain pharmacies or 6.8 percent through mass merchandise

pharmacies or so on. You haven't done any investigation into the accuracy of any of the numbers that are contained in this chart; correct?

A. What I -- what I -- what I know is that the chart in general is consistent with my understanding of how the market structures, functions, and I pulled the chart from an authoritative source.

Q. Okay. But to answer my question, you don't know whether or not any of the numbers that are in this chart are accurate; correct?

MR. COHEN: Objection. Asked and answered.

A. I did not verify back to original research any of the numbers on the chart.

BY MR. DOBIE:

Q. All right. And you've never -- other than as an expert in this case, you've never had a reason in your experience, sir, to prepare or put together any chart like this yourself, have you, breaking down the amount of -- whether between private insurance, public insurance, pharmacy benefit managers on a nationwide basis, how payment for prescription drugs works across

the country?

A. No, that's not correct. I -- when I'm working with segments of the market, I have to understand their footprint in the industry. So that when I'm dealing with ERISA trusts or a more recent example is with the independent pharmacists in southern California, I get a feel in that engagement as to how big a footprint in the industry I'm dealing with. And these numbers are quite consistent with all of that background.

Q. All right. Take -- take the example you just gave. Pharmacists that want to dispense a pharmaceutical product rather than having doctors do that in southern California. Okay. How does your background in doing that give you a foundation to know that the source of payment for prescription drugs in 1999 came 64 percent from private insurance, 19.7 percent from public insurance, and so on, all the numbers that -- that are in here?

A. I know -- I know from the fact that the independent pharmacists are my clients. I know during my conversations with them where their payment sources generally come from. I know from

published information roughly what their percentage of the market they represent. So I know Bergen, for instance, is the wholesaler that -- that works with most of them and I've have had many conversations with Bergen as to what percentage of the market the independent pharmacies are.

So it's not -- the point I'm making is I have verified everything in this report from various sources just by the fact that I'm involved in the market on a daily basis.

Q. Has anyone ever hired you, sir, to examine the -- to prepare any analysis that's like on Page -- Page 13 of your report, the source of payment for prescription drugs, to do that type of an analysis?

We've gone through all your jobs and we can go back to them. I got all night.

A. The closest I would get to -- to an affirmative on that would be that I have worked within PCN and the contracting officers for their network. It has been within that context that I've gotten an understanding of what these independent pharmacies are like, how many of them

they -- how -- how populous they are within the networks. And I've got a feel for where they get their product and where they get paid.

Q. Okay. I understand you have a general sense, okay, as somebody who's been in the industry. All right. But as -- I mean, certainly there are -- there are people, for example, the folks that prepared this chart that you've now put in your report, that actually have done studies like this and have an understanding as to the accuracy of the numbers that are in that chart.

And my point is, you might have a general feel that yes, money comes from private insurance, public insurance, and then goes down to either retail pharmacies or institutional pharmacies and on its way down to corner drugstores and hospitals and stuff, but can you attest under oath in front of a jury as to the accuracy of the information that's here?

MR. COHEN: Objection.

Argumentative. Asked and answered.

A. I can attest to the fact that I pulled the data from an authoritative source.

BY MR. DOBIE:

Q. Okay. And what's the authoritative source?
A. Mr. Schondelmeyer I believe is the authoritative source on this one.
Q. Okay. And --
A. This was -- this was a slide that he used in a presentation to the World Bank.
Q. And where did you get it? Off the Web?
A. I either got it off the Web or out of an article that he had written earlier.
Q. And do you know what Mr. Schondelmeyer did to determine the accuracy of the information that's contained here?
A. I looked at his material and the sources that he used, and in general he's pulling data from published material that he's used before.
Q. Okay. Have you had discussions with Mr. Schondelmeyer about this data?
A. No.
Q. All right. In the preparation for -- for the other charts that are in your report, for example, on Page 12, that also came

from --
A. Same source.
Q. -- from -- it says "PRIME Institute, University of Minnesota."
A. That's Mr. Schondelmeyer's institute.
Q. Okay. And again, I assume you haven't discussed it with Mr. Schondelmeyer?
A. No.
Q. And you haven't done anything to confirm the accuracy of the numbers that are contained in this chart?
A. Correct.
Q. Just a general matter, I just want to understand how -- when you're putting your expert report together and you're going around on the Web finding things that you think are supportive of your experience and then putting them into your report, what was the -- what was the standard that you applied in determining whether or not you'd include it or not?
MR. COHEN: Object to the form.
A. There are two ways to look at generating a report like this in my mind.

One is that you have a detailed knowledge of -- and background on every issue that you -- or every detail that you put in the report. For instance, the slides that you've referenced here in this last set of questions, knowing that a given percentage of the distribution of product goes to a given section would be a very few people in the country that would actually know that. You would generally rely upon referenced authoritative sources. Likewise, there are other areas within the report, for instance, dealing with rebates, you could argue that the advantages to have actually negotiated a rebate to be able to render an authoritative opinion on rebate contracts.
There's a second way, however, to look at all of this, which is where I come from on preparing this report. My background gives me a broad overview of how the health care system works. I -- on creating the report as it related to background information and data, I would pull information that was consistent with my broad experience in the industry, and that's how I would include these items.
BY MR. DOBIE:

Q. Okay. So let me -- let's -- let's just use another example.
MR. COHEN: I'm sorry. Were you finished with your -- your answer?
A. I was just going to say that I come at this from the perspective of understanding the mosaic, not the -- not the placement of one -- one of the tiles within a mosaic. And I did not add anything to my mosaic that I was not comfortable with and was not consistent with my overview of how the industry works.
* * *
(Whereupon, Gibson Exhibit 10 was marked for identification.)
* * *
BY MR. DOBIE:
Q. Okay. Let's look at Exhibit 10 for a moment. And for the record, Exhibit 10 is what, sir?
A. It is pulled from the Web from a source that is entitled "HealthLeaders."
Q. Okay.
A. Information to lead.
Q. And what is HealthLeaders?

A. I believe HealthLeader is a -- I believe that they are a publication. I'm not certain of that.

Q. Have you ever used HealthLeaders before for anything?

A. I'm certain I've run across them in general reading, but no.

Q. Do you know Mr. Dickman, who is the author of the article?

A. I know that the exhibit here says "By Tim Dickman."

Q. Do you know Mr. Dickman?

A. No.

Q. Do you know whether or not he's an authoritative source for the information that's contained in the article?

A. I -- no, I don't know much about Mr. Dickman.

Q. Do you consider HealthLeaders an authoritative source for the information?

A. It is -- I consider it to be a --in the general category of trade journals.

Q. All right. And so does that mean it's authoritative in your view?

A. I think it's -- I think it's a reliable source of information.

Q. Have you ever heard of it before you did your report?

A. I don't recall. I think I have.

Q. And what about the AIS Pharmacy Benefit Group in this article that we marked previously as Exhibit 9; is that an authoritative source of information?

A. That was a source in a source that was authoritative.

Q. What's the source within the source?

A. If you'll pull --

Q. It's right here.

A. No. But if you will pull the -- I will have to go through my report to get it for you, but one of the slides that I included contained AIS as a source.

Q. Okay. And in going back to the HealthLeaders article --

A. Do you want to stay on this point or not?

Q. I heard your answer.

A. Okay.

Q. Exhibit 10, if we could turn to that.

A. I'm sorry. Can I just tell you?

Q. Sure.

A. It was on Page 37 and it was the -- AIS was the source for the slide dealing with tiered copayment structures.

Q. Okay.

A. And as an example, that tiered copayment structure looks about right.

Q. For what time period, sir?

A. This was back in the early 2000s. This I think was referenced at 2002.

Q. All right. And when you say it looks about right, what about it looks right to you, sir?

A. The definition of how the -- what -- what it says on the slide as far as your tiered copayment, and I don't believe this particular copy that I have has all of the information on it. There may have been information above the columns. But you have -- you have a general definition of what the copayment is for a brand versus a generic.

And then on the first tier and on the second tier, it goes on to 15-20 for the first month's supply and brand name drug with no generic equivalent, and it generally outlines what the tiered structure would look like, and that's certainly consistent with my experience.

Q. All right. And the years that AIS was looking at in connection with the preparation of this chart, do you know if it's 2001, 2002, or 2000?

A. I don't know, but I don't think it makes much difference.

Q. All right. Okay. And so when you're saying that this is consistent with your experience, do you know whether or not, just for example, a third-tier copay in 2002 was on average between $25 to $30?

A. I think that's consistent with my understanding. I have more authoritative sources quoted in the -- in the text.

Q. Do you know in 2000 whether the third-tier copays were between 25 and 30?

A. I would refer you to -- on Page 36. This is data from 1999 and this is IMS, which is

probably the most authoritative source.
Q. Okay. And what --
A. And then just below that average copayments, which is what you're asking for, in the year 2002, and I use the reference Scott Levin, which is pulled directly from Wyeth's documents.
Q. All right. So in 2002, for example, the Wyeth document says it's $34, is the average co -- copayment. The document that you have on the next page of your report says it's 25 to 30 dollars.
What -- what is correct, or don't you know?
A. I don't know for sure.
Q. All right.
A. And I don't think again it makes a lot of difference.
Q. But at the end of the day, what you did in preparing in your report, sir, is you just took information from -- from other sources and put it in your report?
A. Yes. I did not go out to the market and do a market research study on what the

copayment values were by year to put in my report.
Q. And, in fact -- let's go back to Exhibit 10. What you did do in your report is -- this is another -- it's right next to you. This is another example where you have simply taken information from another author, put it in your report without quotations, and then referenced the source generally after the quotation; correct?
A. I did not -- I did not put quotations. I did reference the article.
Q. All right.
A. And I did not put in material that I did not find consistent with my experience.
Q. In the -- on Page 23 of your report, in the first paragraph on that page where it says, "Critics charge, not altogether unfairly, that the current rebate structure" -- do you see that?
A. I do.
Q. That was just lifted from the HealthLeaders article word for word, wasn't it?
A. It could be. Do you -- do you have the point on the HealthLeaders article where it came from?
Q. Well, you wrote your report, sir.

Do you remember where you got it?
A. Well, give me a minute and I'll look over the paper.
Q. Look in the -- under "Disclosure of Rebates," the second paragraph.
A. Yes. That's -- that's what's in this article.
Q. Okay. Who are the critics that Mr. Dickman is referring to?
A. I don't know for sure who Mr. Dickman was referring to. I do know that what the verbiage says is consistent with the -- over the general reading I have done and the critical comments about the rebate structures and PBMs' method of doing business, and it's -- all you would have to do is read the Wall Street Journal to -- to confirm that.
Q. Okay. So somebody reading the Wall Street Journal would understand that critics are charging, not -- not altogether unfairly that the current rebate structures create built-in conflicts of interest?
A. It's the basis for --
MR. COHEN: Object to the form.

A. It's the basis for most of the suits that attorneys general in New Jersey -- in New England and elsewhere have been filing against PBMs, particularly the Merck-Medcos.
BY MR. DOBIE:
Q. Okay. And so Mr. Cohen, for example, could he read this article and by the same token reach the same conclusion?
MR. COHEN: I'm probably a bad example.
A. I think any reasonable observer of the industry reading regularly both the lay and professional literature could make that statement.
BY MR. DOBIE:
Q. Okay. And is that true for -- for most of this background material that you have, sir, where you've -- where you've taken it from other sources?
A. Well, some of it, I've taken it from others and some of it is -- is text that I've generated. And I've -- your -- we've made -- you've the point several times that I didn't use the quotation marks, but I did try to put in the references where I pulled material from.

Q. In the discussion that you had previously about -- let me back up a little bit.

The reference previously -- with the exception of Mr. Bystrom's report; right? The only reference to Mr. Bystrom's report is in that footnote that we were looking at before on Page 44; right?

A. Correct.

Q. All right. This -- this process that you described before that you and Mr. Bystrom went through to prepare the reports in the Duramed case, do you -- do you keep a computer, sir, at your home?

A. Sure.

Q. And what kind of computer do you have?

A. It's a desktop computer. It's made by -- what's the company that looks like cows?

Q. Gateway?

A. Gateway.

Q. How long have you had that computer, sir?

A. Three years -- three years or so.

Q. So did you have it at the time that

you did your report in the Duramed case?

A. I don't recall if I had it at that time or not.

Q. Do you use e-mail?

A. Yes.

Q. Have you had the same e-mail service in the last three years?

A. MSN.com.

Q. Do you have any other computers besides the Gateway?

A. Yes. I have a laptop that's provided to me by PCN and I have a PCN e-mail address.

Q. How long have you had the laptop that you got from PCN?

A. From the time I started with the company.

Q. Sir, I want to talk about your experience with contracting with pharmaceutical companies.

At the time of your last deposition, you told me that you didn't have any experience negotiating with manufacturers of pharmaceutical products; correct?

A. Correct.

Q. And since your deposition, you haven't gained any experience in terms of negotiating with manufacturers of -- of pharmaceutical products; correct?

A. Direct contracting, no.

Q. And you haven't negotiated any market share rebates or anything like that with any pharmaceutical companies since your -- your last deposition; correct, sir?

A. Correct.

Q. And given that you haven't negotiated rebate contracts with any manufacturers, sir, do you know how common exclusives are in the industry?

MR. COHEN: I'm sorry. Can you read that question back? I didn't -- I didn't quite get it.

MR. DOBIE: Yes, I'll just restate it.

BY MR. DOBIE:

Q. At the time of your last deposition, sir, you told me that you had never negotiated a rebate contract with a manufacturer and it's not

something that you had -- because of that, you didn't have knowledge of how common exclusive contracts were in the industry; correct?

A. Correct.

Q. All right. And you still don't?

A. Incorrect. Since that time two years ago, I've been in an operating environment in a PBM. I didn't negotiate the contracts, but i've had regular conversations with people who do.

Q. Who do you have regular conversations with at PCN that negotiate rebate contracts?

A. There was -- one of the pharmacists -- first of all, I visited with John Scull, who is the CEO of the company. I visited with David -- I can't remember the name. The chief financial officer for the company who's regularly involved in these negotiations. And there is -- there was a pharmacist that was involved. His name is -- let's come back to that and I'll give it to you. It's just -- I'm not -- I didn't come prepared to give you that -- his name. But --

Q. It's a he?

A. It's a he.
Q. And what's your understanding of his responsibility, this pharmacist?
A. His -- his responsibility was the lead negotiator on the rebates when we brought the formulary back inhouse.
Q. And is this somebody who's an existing employee?
A. No, he's no longer with PCN, but he was up until about the last month.
Q. Okay. So in the process of preparing a formulary for PCN, did you have discussions with the CEO of PCN, this pharmacist that you can't remember the name of, and the CFO concerning the question of how common exclusives were in their experience?
A. I asked that question, how often do you see exclusive contracts negotiated, and furthermore how often do you see these tied contracts where you are tying multiple products together. And the answer I got -- what was that?
Q. I was just asking you if the CEO and the CFO had never before themselves negotiated a manufacturer contract because PCN hadn't been

doing that.
A. No, but they've been involved since we brought it back inhouse.
Q. In 2003?
A. Correct.
Q. Okay. So in --
A. And I'm just telling you that things changed from my last -- from our last visit together till now where we have an operating PBM environment where this is routinely done.
Q. All right. So here's what I'm getting at. So you were asking them now that we've brought it back inhouse, what are you seeing in terms of what manufacturers are asking for in terms of exclusive contracts?
A. No. I had been involved in the Duramed case.
Q. Right.
A. And so I was curious. Is this -- I wasn't going to go into great detail, because I had all the confidentiality agreements with the Duramed. But I just asked in general do you see often these exclusive relation -- contracts, and the answer was it's not that common. It didn't

have percentages attached to it, but it was -- it was not a common thing, and it was particularly uncommon to have these tied relationships, product-tied relationships.
Q. Okay. Let's make sure I understand it.
Who was it that told you first that exclusives are not that common?
A. It is -- the first person that told me that was John Scull. The second person was David -- I want to say Norwood, but that's not right. And the third was this pharmacist that I'm having trouble with his name right now.
Q. And they were telling you that based upon this -- when was it that you had this discussion with them?
A. When?
Q. Yes, sir.
A. Some time in the last year.
Q. Okay. So in -- was it you were asking them what were they seeing in the course of -- of contracts that were being offered to PCN --
A. Right.

Q. -- during 2003?
A. Yes.
Q. Okay.
A. And -- and I would just say also that -- and I apologize for the fact that I'm not giving you the name right now, but the contracting officer, the pharmacist that I'm referring to, had also done this contracting at another PBM in the past. So it wasn't just he'd been brought in from the outside to help with this.
Q. Okay. And the other person that -- you had John Scull, and then the CFO of the company is the other person that told you this?
A. I don't recall that the CFO told me. It was John Scull and this contracting officer.
Q. And the contract officer. Okay. And they both told you that based upon the --
A. Their experience and understanding.
Q. Can I finish the question, sir?
A. Yes.
Q. They told you that based upon -- let's start with Mr. Scull first. All right. Strike the question.
Mr. Scull told you that in this time

period since PCN began handling its own contracts with manufacturers, which began in 2003, that he did not find that exclusive contracts were that common; is that correct?

A. That was not the question I asked nor the question that he answered.

Q. All right. Well, tell --

A. The question I asked was, is it your -- is it your experience based on both branded formulary inhouse and on your general understanding of the industry, because he's been in it for many years -- is this an unusual thing to see, and the answer was that I told you.

Q. Okay. So Mr. Scull told you that exclusives were not that common?

A. Correct.

Q. All right. And did he say that exclusives were uncommon?

A. I don't recall that he said it was uncommon. He just said that he didn't see it that often.

Q. Did he tell you that PCN had exclusives?

A. I don't recall that he told me.

Q. Did you -- did you -- after -- after hearing this, did you yourself inquire as to whether or not by exclusive -- let me back up.

When you asked him about exclusives, were you talking about the only drug in a therapeutic class?

A. Yes.

Q. Okay. And -- and so when they said that an exclusive -- exclusive is not that common, they were saying that it's within a therapeutic class; correct?

A. Generally we would offer a couple or more of brand products within a class.

Q. All right. And so, for example, in the estrogen category, estrogen replacement therapy category, PCN does, in fact, offer a variety of products in that category; correct?

A. Correct.

Q. It does not have an exclusive on -- on conjugated estrogens; correct?

A. I don't know.

Q. All right. And does it have a --

A. Let me just back up one second.

It's very important here on

Q. Did -- did you come to find out that PCN had exclusives?

A. I didn't pursue it further.

Q. You had the discussion with this pharmacy who is the contract manager -- pharmacist?

A. Correct.

Q. Okay. And tell me exactly what he said in terms of whether or not exclusives were common.

A. It was consistent with what John Scull had told me and that I related in this testimony.

Q. Okay. But I want to be as precise as possible.

This pharmacist told you that exclusives were not that common?

A. Correct.

Q. And did he say that PCN had, in fact, exclusives?

A. He didn't tell me that.

Q. Did he say exclusives were not uncommon?

A. He said they were not common.

definitions. For instance, what tier are we on here? In other -- you know, are you asking was conjugated -- was Premarin the only conjugated estrogen or the family of Premarin the only conjugated estrogens on the second tier and -- and the third tiers --

Q. That's not my question.

A. -- are different?

Q. My -- my question is -- I'm following up with you on your discussions with Mr. Scull and with the pharmacist, the person that's the contract manager. All right. And when they're saying that exclusives are not that common, what they were saying is that exclusives are not that common in the therapeutic category, within a therapeutic category?

A. Yes.

Q. You would not have only one branded product within a whole therapeutic category; correct?

A. It would be unusual.

Q. All right. Do you know whether PCN, in fact, has any exclusives within an entire therapeutic category?

A. No, I don't.
Q. So as the head of the P&T committee, have you ever reviewed PPIs, for example, at PCN?
A. We did review -- let's see. Did we? We reviewed SSIs. I don't know -- I don't recall if we reviewed PPIs or not.
Q. You've had four or five meetings?
A. Yes.
Q. And -- and do you know whether or not you've reviewed the insulin category?
A. No, I don't believe we reviewed insulin.
Q. Did you review the oral contraceptive category?
A. Let me -- let me back off a second and here and answer --
Q. Can you just -- can you just answer?
A. The answer is no.
Q. All right. Did you review the COX inhibitor category?
A. No.
Q. All right. And do you know whether or not -- even though you haven't reviewed those as somebody who's the medical director of PCN, do

you know whether or not PCN, in fact, has an exclusive -- and by that I mean the only one within that therapeutic category -- for either PPIs, COX inhibitors, oral contraceptives, estrogen replacement therapy, and insulin?
A. I will tell you on the estrogen replacement, that on the second tier Premarin is the -- and -- and the family of Premarin are the drugs that are -- that are on the second tier. Drugs like Cenestin are on the third tier.
Q. So it's your understanding that you have an -- you have an exclusive as it relates to Cenestin within the estrogen therapy category -- I'm sorry. Let me restate the question.
It's your -- it's your belief, sir, that PCN has made Premarin and the Premarin family of products an exclusive on the second tier of the formulary since 2003?
MR. COHEN: Object -- object to the form in terms of the use of the word "exclusive" with respect to the second tier.
A. I do not know anything about the contract with -- with --
BY MR. DOBIE:

Q. That's not my question.
A. I will just tell you what I know. Do you want --
Q. No. I want you to answer my question, sir.
MR. DOBIE: Would you read the question back?
* * *
(Whereupon, the requested portion of the record was read.)
* * *
A. And the short answer to that is I don't know.
BY MR. DOBIE:
Q. So you don't know whether or not, for example, estradiol is on the PCN formulary in the second tier or even the first tier?
A. If you pulled the -- if you pulled the formulary, it doesn't appear on -- on the formulary I pulled down off the net.
Q. When did you do that, sir?
A. I pulled it down just before I came up here.
Q. And the only product that you're

showing on the second tier or first tier is Premarin?
A. Is Premarin family of drugs, is as I recall what was on the second tier.
Q. All right. And did you -- at the time that PCN created a formulary in 2003, did you, sir, as the head of the P&T committee decide to make Premarin the only product in the second tier?
A. No.
Q. Do you know who did make that decision?
A. It was probably inherited from the company that we had dealing with our formulary before.
Q. The company --
A. That is PCS.
Q. AdvancePCS, sir, in 2002 had Cenestin on their formulary and not Premarin.
A. Okay. Then I don't know.
Q. All right. You're just speculating when you said that you think it came from the prior company?
A. That's correct.

Q. All right. So do you know who within PCN would have made the decision to put Premarin on the formulary in the second tier other than you and the other members of the P&T committee?
A. No, I don't. There's a lot here that I'm not telling you, but we'll leave it.
Q. We have a lot of questions and answers --
A. Yes.
Q. -- still to go.
Do you know, sir, somebody the name of Debrea Napior?
A. The name is familiar. Who -- could you tell me who she is so that I could try to put a name with a face?
Q. Does that -- you don't -- that doesn't ring a bell?
A. I believe I have heard "Debrea Napior," before but I don't -- I'm not putting it together with the person.
Q. is that -- do you know, is that somebody who -- whose article that you cited as an authoritative basis for anywhere in your report?

Does that ring a bell?
A. It is, but I don't -- it doesn't jump to my mind right now.
Q. And to go back to the question I asked a moment ago, you -- you mentioned the Premarin situation, but do you know whether or not PCN had a single source or exclusive contract for insulin products?
A. No.
Q. You don't know?
A. We covered that and I didn't know.
Q. Okay. And you don't know as it relates to PPIs or COX-2 inhibitors or oral contraceptives either?
A. Correct.
Q. Sir, other than the discussion that you had with Mr. Scull and the pharmacist whose name you can't recall who told you that exclusives are not that common within a therapeutic category, is there any other experience that you've had that allows you to provide an opinion as to whether or not exclusive or sole conjugated estrogen-language contracts is common or not within the industry?
A. I had the same discussion with Mr.

Bystrom, who indicated pretty much the same thing as Mr. Scull has.
Q. Okay. So you had a discussion with Mr. Bystrom. Anything else, sir?
A. I believe I had a discussion with some of the officers in the California Pharmacists Association, but I don't quote those as authoritative because they're not -- these -- these rebate contracts aren't between the retail level and the pharmaceutical manufacturers.
Q. Well, there are -- there are -- there are contracts between retailers and pharmaceutical manufacturers?
A. Yes, but not rebates generally.
Q. Are you familiar with pharmaceutical manufacturers and retailers actually having rebate contracts?
A. No. But I'm familiar with the fact that the distribution of product can go directly from the pharmacy manufacturer to the retailer.
Q. All right. That wasn't my question. You are -- just answer the question.
You are not familiar with the practice of pharmaceutical manufacturers paying

rebates to retailers?
A. Correct.
Q. Sir, given at your deposition in 2002 you had no experience with these exclusive contracts, as you yourself have testified, whether it was common or not common, and you referred to others, and you've had one discussion with Mr. Scull, one discussion with this pharmacist, and a discussion with Mr. Bystrom, how is it that you think it appropriate for you to give an expert opinion to a jury as to how common exclusives are in the industry?
A. I am giving an opinion based upon conversations I've had with people in the industry who do this regularly.
Q. Okay. Those three conversations we've identified?
A. Yes.
Q. How do you know, sir -- all right. So now that you've had these three people that told you that exclusives are not that common within the therapeutic category, how then, sir, are you in a position to comment as to what impact exclusives or sole -- sole product in the

therapeutic class agreements would have within the marketplace if you don't know within even your own company whether you have them or don't?

A. Well, those are two different issues.

Q. Okay. Can you -- can you -- let's go to the first issue.

You've told us your basis for whether you know about exclusives or not. All right. What I'm now interested in is, are you trying to give an opinion, given what I'll call the limited basis of your knowledge, on how common exclusives are? Do you actually think you have the expertise to then go the next step and give a further opinion as to how common or what the impact is of those --

A. Absolutely.

Q. -- agreements are in the marketplace?

A. Those are two -- two different issues. The first you're asking is my direct knowledge of the incidence of exclusive contracts, and i've given you hearsay information. The second part is my experience with what those kinds

of contracts do within the market once they're negotiated.

MR. DOBIE: Okay. Let's -- he's got to change the tape.

THE VIDEOGRAPHER: This is the end of Tape No. 2. The time is 2:59 p.m. We're off the record.

* * *

(Whereupon, a discussion was held off the record.)

* * *

THE VIDEOGRAPHER: This is the beginning of Tape No. 3. The time is 3:01 p.m. We're back on the record.

BY MR. DOBIE:

Q. Dr. Gibson, let me ask you, if you don't know whether or not exclusive contracts are common or not, don't even know whether you have them or don't have them on the PCN formulary, how is it that you can testify as to the impact that those agreements that may or may not exist even within PCN have in the marketplace?

A. Testifying as to the effect in the marketplace deals with choices that are presented

in the clinical setting. Exclusive contracts would limit those.

Q. Okay. So exclusives would limit -- when you're talking about in a clinical setting --

A. The drugs --

Q. -- you're talking about two physicians?

A. The drugs that are available to physicians and patients.

Q. All right. I understand your expertise there. All right. I'm not quarreling with you on that.

I mean, if what you're saying is is that you can testify as to how an exclusive would limit the options for physicians and patients, you're a physician and -- I mean, I've got your resume. I understand your expertise on that. Okay. What I am talking about -- is that what you meant by your answer?

A. Yes.

Q. Okay. All right. Here's what -- is it that -- are you trying to hold yourself out, though, sir, as -- as somebody who can testify as to the impact of an exclusive, not to physicians

and patients, but instead within the broader marketplace including, for example, to Duramed?

A. Well, it's -- as I see it, it's all pretty much the same thing. Once -- once the options are limited contractually, it has an effect in the marketplace and it has to be reflected within the clinical setting because drugs are ordered there.

Q. All right. Here's where I've got a disconnect I think with you.

How is it -- I would assume that you'd agree that there's a lot of different attributes of a product that will lead to its success in the marketplace; right?

A. Yes.

Q. A pharmaceutical product -- how many -- whether it's a breakthrough product, for example.

A. Correct.

Q. Whether it's a -- whether there's a lot of folks out detailing and explaining the product to physicians.

A. Correct.

Q. How much research that there is

behind the product.
A. Correct.
Q. Those are all different things that I assume that you as a physician are familiar with as can impact the uptake of a product in the marketplace?
A. Correct.
Q. All right. What I am -- what I'm -- what I'm wondering about is if you don't know in any of these categories, for example, PPIs, COX inhibitors, whether exclusives are or are not in place at PCN or other pharmaceutical companies, how is it that you can give a opinion as to whether or not a product will or won't be successful in the face of an exclusive?
A. Well, first of all, the issue of anyone being able to come in and testify as to the existence of exclusives without benefit of a discovery process similar to what we've gone through in this case couldn't testify to that.
I think your issue is that you're having difficulty that I don't happen to know the status of those drugs at PCN, which in reality if you look at the landscape of the pharmaceutical

market is a pretty limited footprint.
Q. Well, let me give you an example.
There are people who are hired by health plans to negotiate with PBMs, the pharmacy benefit, for the members of the plan; correct?
A. Correct.
Q. And people like that know, okay, here's -- here is a -- the type of contract that we would typically get with a -- with a particular PBM and, you know, we typically see three or four choices in insulin or we see one choice in PPIs. There are people that are familiar with how common multiple choices are within therapeutic categories as a -- as a result of consulting with plans to shape their -- the formulary choices of the members; right?
A. Correct.
Q. You won't do that?
A. That's not the question you've been asking me.
Q. Okay. All right. But if I ask --
A. Am I aware of that?
Q. -- you that, you don't do that?
A. I'm aware in general what the

formularies are for the competitors to PBM and whether or not there's single options within a therapeutic class on the branded side. I have a general feeling for that. And that's -- that's -- that's exactly what an officer within a HMO would have. The officer in the HMO would not know if these are exclusive contracts or not. Those are private contracts between the PBM and the manufacturer.
Q. You're saying that an officer of a particular PBM as yourself?
A. I'm not an officer of a PBM.
Q. Let me -- well, let's not talk about what other people know or don't know. Let me ask you what you know.
Do you know, for example, whether or not there are exclusives in the PPI, oral contraceptives, COX inhibitors, oral contraceptives, estrogen, any of the other PBMs separate and apart from the work you've done?
A. I don't --
MR. COHEN: Objection. Asked and answered.
A. I don't know and I don't think

anybody else does in America other than the -- other than the people that actually negotiated so that -- and a given PBM officer and a given pharmaceutical company would know whether their drug was an exclusive arrangement, but other pharmaceutical companies wouldn't.
BY MR. DOBIE:
Q. Okay.
A. Nor would other PBMs.
Q. But somebody consulting for a -- for a health plan would know whether or not -- if they go to Express Scripts, if they go to PCN, if they go to Medco, whether or not they're -- what kind of choices they're being offered?
A. They'd know what choices.
Q. And they --
A. They wouldn't know if -- the terms of the contracts they had with the manufacturers, nor would they know if they were exclusives.
Q. Let me finish. Wouldn't they know whether or not they were being offered a health plan for their members that had more than one product on formulary?
A. They would know what the

formulary -- they would know what the health plan's formulary is.

Q. All right. And --

A. I mean the PBM's formulary.

Q. Okay. And they would know whether or not the PBM was listing one product in the PPI category or three; correct?

A. Correct.

Q. And they would know whether or not there was one product or three in the COX category?

A. Correct.

Q. Same thing. One or three in the oral contraceptives.

I mean, we could go through the whole list. They would know that much; right?

A. They would.

Q. And they would also know whether or not -- if they asked, whether or not there were rebate dollars that were going to be passed down to them; correct?

A. Correct. But -- but what you're asking is is there an expert who could tell you what the contractual relationships are for

exclusive relationships across the industry, and I would argue that nobody knows that.

Q. Right.

A. I mean, those are all proprietary agreements.

Q. All right. But going back to the example that -- that I gave, you're not in the position -- you're not in the position, though, of somebody like what I described before, who advises the plan and can tell them what they're going to get -- you're going to get, you know, one of one insulin at -- with Express Scripts. You're going to get -- you're going to get two COX products at Medco. You're not a person that engages in that type of a consulting practice; right?

A. I'll give you -- that I do, but it's not exactly as we've discussed up till this point.

Within the context of the data mining that I do, I know -- I know who the PBMs are for the plan and I know all the drugs that have been dispensed. So I know exactly what's on their formularies and what are coming out as dispensed items.

Q. Those are the --

A. I don't know anything about the underlying contractual relationships.

Q. Okay. But again, you've had two projects as it relates to that; correct?

A. No. But you asked whether or not in the course of my regular activities, if I would have access to that kind of information, and I would -- I'm giving you an instance where I do.

Q. Okay. In those two instances, you know whether or not they typically prescribe multiple or only one product within the therapeutic class?

A. I know by class every drug that was dispensed.

Q. That's all on a -- on a -- in documents that you have?

A. It's on the -- it's on the pharmacy claims data --

Q. All right.

A. -- that goes into the data warehouse.

Q. Have you made any study, sir, that examined how many products within a particular therapeutic category the members are -- are being

prescribed for either of the two plans where you've undertaken that process?

A. Yes, I did on both.

Q. You did.

A. And --

Q. And with both categories, did you -- with both of those two clients, did you -- did you make any investigation in terms of whether or not any of the products were prescribed pursuant to prior authorization?

A. No.

Q. Did you make any examination in terms of whether or not the products were either in a first, a second, or a third tier?

A. No. I knew what was dispensed and what was -- and what was paid.

Q. All right. And this report that you're talking about, did you -- did you provide that to the folks that -- that hired you in connection with this --

A. No.

Q. -- project? Do you have that report today?

A. No.

Q. Why did you prepare the report?
A. I prepared the report about four weeks ago.
Q. Okay. On your computer?
A. Uh-huh.
Q. Which one?
A. The one in my home office, the desktop.
Q. Did you retain it?
A. I have it, yes. The one --
Q. And are you --
A. -- problem here within --
Q. Let me -- let me ask you this: Are you relying upon that data or information as part of the conclusions and opinions that are -- you are offering here today?
A. It would only be tangentially. The issue came up in the context of the question you asked.
Q. Okay. But you're -- you're telling us that you are now -- well, I was asking you, sir, about your experience with negotiating contracts and whether or not you can give an opinion as to the impact in the marketplace of

exclusives.
A. If I recall the question I was answering, you were asking whether or not as an individual involved with the industry, whether I would know, like others do, whether health plans had multiple options within class. And I was being responsive in answering that I do have access to that information, though it's not a major part of my practice yet.
Q. Did you make an examination as to whether any of the products that are -- that you reviewed were either on formulary or off formulary?
A. No. I made a -- I made -- I have access to outcomes, what were actually dispensed.
Q. As it relates to these -- these -- tell me the names of the two -- two groups for whom you prepared this report.
A. I'm not sure I'm prepared to give you those names, given the fact that this is under HIPAA.
Q. I'm not asking for patient information.
A. I know, but even the clients' names,

I'm not confident that I can give you that information. I'll be happy to do it if there's not a -- if there's not a problem with it, and I will check on it. But certainly giving you a copy of a report with patient names on it, I could not do that.
Q. You could delete the patient names.
What I'm -- what I'm trying to understand, sir, is in this instance, as you just described, if you don't know whether or not any of the products that were dispensed were prior authorized first, second, or third tier, what the formularies were or weren't for either of those plans, how is it that you can rely upon -- or are you relying upon that work in forming your opinions as --
A. No.
Q. Okay.
A. I'm not -- I'm not relying on it, but that was not what I was -- that wasn't the question I was answering.
Q. Well, we misunderstood each other then.
So -- so then in terms of your --

your experience and the ability to testify as to what impact exclusives or sole contracts within a therapeutic category have in the marketplace, being on formulary or off formulary, if you haven't -- and you don't know which products are or aren't in exclusive position, how can you give an opinion as to the impact of those exclusives, what that would have in the marketplace beyond the physician-patient realm?
A. Well, the major access I have that gives me authority in this instance is the documents supplied by Wyeth in discovery.
Q. All right.
A. Based on that, I know what contracts were exclusive with the various MC -- MCOs that had captive PBMs and the various PBMs in the marketplace, the major PBMs that have footprints in the market.
The reason I don't know the data relating to PCN is it's a fairly marginal player. So I didn't have access to PCN documents to be able to review, but it's that information which gives me the ability to comment on contracts and their effects.

Q. I just want to make sure I understand that.

So -- so the -- we've identified now your discussion with Mr. Scull, the discussion with the pharmacist, the discussion with Mr. Bystrom, and now you're saying that you've had access to the documents in this case?

A. Correct.

Q. All right. Is there anything else that you can think of that gives you a basis to form your opinion as to what effect an exclusive contract has in the marketplace separate and apart from how it may impact on patients and physicians if the formulary is limited?

A. In addition to the issues that I've given to you, the conversations and the --

Q. Yes, sir.

A. -- contracts and all the rest is the authoritative sources that I've quoted in my report and footnoted.

Q. Okay. Anything else?

A. That would be it. And allow -- let me put in. And general reading that I did not put in the report or -- or footnote.

Q. Well, if there's anything else that forms the basis for your opinions, I'm entitled to have that. So can you identify any other general reading that forms the basis for your opinions?

A. I read all the time. I read both the professional and the lay literature all the time. If it didn't rise to the level of being critical for this report, I didn't include it nor footnote it.

Q. All right.

A. But I read generally constantly. So I can't, you know -- I read five newspapers every day and read most of the medical journals.

Q. All right. Well, if -- the way that the rules work and the way -- in terms of both side is if there's some other source that forms the basis for your opinions, I'm entitled to know what it is, I'm entitled to review it and see whether or not there's something in there that I might ask you about to test the basis, the foundation for your conclusions.

A. Well, fair enough.

Q. So --

A. And I -- within the context of the

rules and the fairness issue, what I have written and what I have footnoted is the basis on which I'm forming my opinions.

Q. Okay. Fair enough. All right.

Let me ask you about another area that was previously covered by Mr. Bystrom, and that relates to the pharmacy side. And in your last deposition, I asked you if you knew how it worked between -- if a -- if products were on a third tier, whether or not they'd be -- whether they would be prescribed or -- strike the question.

I asked you in your last deposition if you knew if a patient walked into a pharmacy and had a product on the third tier, for example, Cenestin -- say Cenestin was on the third tier -- whether you knew whether the pharmacist would dispense the product and charge them a cash price, a third-tier copay, or something else, and you deferred to Mr. -- Mr. Bystrom on questions like that, including that question.

Have you done anything on the work side that now has educated you in terms of how that process works in the marketplace?

A. "The work side" being the real world or was that --

Q. Separate and apart from litigation.

A. Okay. Yes, I have. In my activities with pharmacists across the state of California, I will frequently ask them informally how they handle this situation. Do they -- do they charge the copay if it's higher than the acquisition cost or do they go with the lower of the two.

Q. All right. So let me --

A. Is that the question you're asking?

Q. Yes. Let me give you -- let me give you a hypothetical. All right.

If the cash price for Cenestin -- and you can write this down -- was, let's say, $27.

A. Okay.

Q. And the negotiated --

A. I'm not supposed to write on any of this stuff, am I?

Q. Try writing on there.

A. Thanks.

Q. If the cash price for Cenestin is,

let's say, $27 --
MR. COHEN: Cenestin?
MR. DOBIE: Yes, Cenestin.
MR. COHEN: Not Premarin. Okay.
BY MR. DOBIE:
Q. Cenestin is $27. It's on -- the patient has a health plan that puts Cenestin on the third tier, so that it's at $30 copay. that would be the second choice. Or would the patient be charged the negotiated price between their -- their pharmacy benefit manager and the retailer? Let's say the negotiated price was an AWP on Cenestin, $25, minus 10 percent, plus a -- which would take it down to 22.50 plus a $2 handling fee. So that's 24.50.
Would they get charged the 24.50, the negotiated price, in essence, would they get charged the cash price of $27, or would they get charged the copay for a third-tier product, again assuming that the plan had put Cenestin in the third tier of $30?
MR. COHEN: So your hypothetical is -- is not zeroing on in any particular pharmacy chain, any particular type of

pharmacy?
MR. DOBIE: No.
MR. COHEN: Just broadly --
MR. DOBIE: Just --
MR. COHEN: -- any pharmacy?
MR. DOBIE: -- his experience, his understanding of how it works.
A. You've got several things in that question.
BY MR. DOBIE:
Q. Okay.
A. Okay. First of all, you would not normally pass on to the patient the dispensing fee that you negotiated with the PBM. You know, you went from the $24 and added 2.50. So --
Q. Nor would -- the patient wouldn't -- they wouldn't pay that --
A. The patient would normally also pay 2.50 if they'd been paid 2.50 for a dispensing fee by the PBM.
Q. So a pharmacist wouldn't normally charge them the negotiated price in my example of 25 minus --
A. I haven't gotten to that part yet.

Q. Okay.
A. I was just zeroing in on the dispensing fee and whether or not in your hypothetical it would be passed on to the patient.
Q. The charge?
A. Yes.
Q. You don't think so?
A. Well, the charge -- the 2.50 has already been paid by the PBM to the pharmacy as a dispensing fee.
Q. I'm -- here -- let me make sure you're clear on the hypothetical.
Okay. This is a situation where -- where the patient has a Cenestin script. It's on the third tier because the plan has put it on the third tier.
A. Correct. I'm with you there.
Q. Okay. So that we got the $30.
A. You got the $30.
Q. You got the $25 you walk in off the street. And then the last option is that there's actually a negotiated price between the PBM and the retailer where they have an AWP price, average wholesale price, of $25 minus 10 percent, which is

the 22.50, but then they charge a $2 handling fee or service fee on top of that. 24.50.
A. Okay. I'm -- I'm admittedly focusing on part of your answer, not the whole one here, and that's that 2.50 issue.
Q. You don't think they'd be charged that at all?
A. They'd never be charged that.
Q. Because the -- because the PBM would pay that?
A. It's already paid.
Q. All right. So would the patient --
A. So the question boils down to would they be charged the negotiated fee or the copay, whichever --
Q. Or the cash price.
Q. -- is the greater. Or the third option would be the cash price.
Q. Right.
A. The --
MR. COHEN: Could I just -- does the patient that walks in have insurance or not?
MR. DOBIE: This is -- this is the -- I don't know if "insurance" is the

right word, Jay, but it's a -- the plan has got a third-tier copay. That's --

MR. COHEN: This is not a cash-paying customer. It's a customer who has a plan?

MR. DOBIE: Yes.

MR. COHEN: Correct?

MR. DOBIE: Yes.

A. There are no absolutes and furthermore, there's no, to my knowledge, published material to give you a footnote on this.

In general, the pharmacists charge the greater of, the greater of the copay or the acquisition -- well, they can't charge beyond the copay. But if the copay is greater, they'll charge the copay. That's consistent with their behavior across the board for both brand and generic products.

And though we won't go into it unless you want to, the issue of how generics are charged within the market, particularly the mail order environment, is -- is overwhelmingly they're charging the copay amount.

BY MR. DOBIE:

Q. Okay. What's the basis for your conclusion, sir, that -- that the pharmacists would charge the greater of the copay or -- versus either the cash price or the negotiated price?

A. You -- you --

Q. How do you know that? You didn't know that --

A. At the --

Q. -- in your last deposition?

A. Between my last deposition and now, I've had a lot more conversations with pharmacists who are actually dispensing product.

Q. In California?

A. Mostly in California, not all, but mostly in California, Oregon, Washington, and Kentucky.

Q. And they've told you that it's their usual practice in these pharmacies that if their cash price is -- is, let's say, $25, they nevertheless go ahead and charge a higher copay amount?

A. Absolutely. And --

Q. Who are the -- who are the pharmacists that you've talked to that have told

you this? Can you name one?

A. When I visited with people like Walter Carey, who is president of a not-for-profit in southern California that's affiliated with UPNI, that was the feedback I would get.

Q. When did you --

A. I talked this over with a number of the board members from California Pharmacists Association, all of whom are practicing pharmacists.

And to buttress it, the issue of the literature, there was not more than a month ago a major article in the Wall Street Journal dealing with dispensing practices for generic drugs and the pricing of the transaction.

Q. What did the -- what do you recall about the Wall Street Journal article?

A. Wall Street Journal article demonstrated how the dispensing of generics is the highest profit margin within the system. It's a major reason why PBMs with mail orders are moving the dispensing of those products to the mail order pharmacy. And the example they gave was for generic Prozac.

Q. So the PBMs make more money on generics than on branded products?

A. They do now.

Q. Do -- do the dispensing pharmacists make more money on generics?

A. They do now. They always have. Generics have always been more profitable than brand for -- in a managed care environment for a dispensing pharmacist.

Q. Who are the board members of the California Pharmacists Association that told you that they charge higher of the copay or the cash amount?

A. I don't -- I don't -- I'm sorry, but I'm not going to give you the names of the whole California Pharmacists board. I visited with people at various times. I've had this conversation. This is the feedback I've gotten. But I'm not prepared to put quotation marks around it and give you a footnote.

Q. Well, we're entitled to know the basis for your opinion, sir, and if there's somebody who told you this -- you didn't have this expertise. They had another expert, Mr. Bystrom.

Okay?
A. Right.
Q. Now you've got that expertise, you're telling us, and you want to tell the jury, right, and so I'm entitled to know the basis for that opinion that you want to offer.
A. But what I'm telling you is I've these conversations with these people and this is the feedback I've gotten back, but I'm not prepared to say that -- exactly which one of the board members I had the conversation with and got it back from.
Q. Okay. And I understand that you would rather not say, but I'm entitled to know that information.
MR. COHEN: I'm just going to object to -- and I'm not trying to characterize his testimony, but it seemed to me he was saying -- he was really saying he doesn't recall which of these people it was rather than he's withholding a name.
And if I'm wrong about that, he can correct me.
THE WITNESS: Well, that's -- that's

really correct.
MR. DOBIE: Thanks for that -- thanks for that hint, Jay.
BY MR. DOBIE:
Q. So rather than you not being prepared to tell me who it is, now you don't recall who it is?
A. This has come up in the context of your question.
Q. Yes.
A. And I don't recall exactly who gave me the information. I generally know who I talked to about it.
Q. Okay. Who generally do you know that you talked to about this?
A. I talked -- as I mentioned, Walter Carey.
Q. Yes.
A. David Brazelton, who -- who is the head of UPNI and also on the board of CPHA. I visited with a board member from Bakersfield, Clark Gustafson.
Q. Anyone else?
A. And again, I visited with people

knowledgeable in the industry like John Scull. And I visited on several occasions with Dale Bystrom.
Q. Mr. Scull tell you that the practice to his understanding was to charge for pharmacy --
A. It was his understanding that in general --
Q. Can I finish the question?
That generally speaking, pharmacies charge the higher of the copay or cash amount?
A. Correct.
Q. Other than having discussions with these individuals where they've -- where they've told you this, do you have any other basis to offer an opinion as to how it would work in the pharmacy side?
A. I think that that and -- and based on reading, that would be the two sources.
Q. Okay. And the reading is the Wall Street Journal article. Anything else?
A. That's -- that would be the major article.
MR. COHEN: Gordon, are you at a good break point?

MR. DOBIE: Sure.
MR. COHEN: Thanks.
THE VIDEOGRAPHER: We're going off the record. The time is 3:34 p.m.
* * *
(Whereupon, a short recess was taken.)
* * *
THE VIDEOGRAPHER: We're back on the record. The time is 3:47 p.m.
BY MR. DOBIE:
Q. Sir, you mentioned the fact that you discussed with Mr. Bystrom what was the process by which it usually worked. Do you recall that testimony from a moment ago?
A. I do.
Q. And what did Mr. Bystrom tell you?
A. As I recall, he was consistent with what I have testified, that in the hypothetical you are -- you are presenting, that the retail pharmacy would charge the copay.
Q. The higher copay?
A. Yes.
Q. All right.

A. He also said one other thing that was interesting, too, as I recall. It was either he or John Scull. That it really isn't important what the -- what the retail rate was versus the third tier in particularly your hypothetical. The real important thing is the difference between the second-tier copay and either the retail or the copay amount for the third tier.

So if -- if you have a second-tier product in class sitting there at a $20 copay and you have either a 27 or a 30 dollar copay, you're still dealing with a significant delta or difference.

Q. And if it's a $5 copay difference?

A. Well, you've got data that I quoted in here from your own internal sources as to the importance of brand seepage based upon the amount of copay that is in the market.

Q. No. I'm talking about your discussion with Mr. Bystrom or Mr. Scull.

A. Oh. We didn't get to --

Q. You didn't get to that --

A. -- that level of detail.

Q. They just said that the bigger the

difference in copay, the more significant --

A. Sure.

Q. -- that second versus third --

A. Absolutely,

Q. -- tier would be?

Q. Dr. Gibson, if you let me finish the question. Otherwise, we're going to have a pretty confused record here.

What the question was is what you heard from Mr. Scull or what you heard from Mr. Bystrom was that the most important thing was -- I'm not talking about what's in the documents. I'm talking about what they told you -- was the amount of the difference between the second- and the third-tier copay.

A. And what I said was the difference between the second and third tier or the second and the retail price.

Q. Right.

A. That was the point I was trying to make.

Q. Understood. Sir, let me show you what was previously marked today as Exhibit 6. This is Mr. Gibson's deposition. And sir, if I

could turn your attention -- I'm sorry, Mr. Bystrom's deposition -- to Line --Page 57 -- I'm sorry, Page 56, Line 23. He's asked -- Mr. Bystrom is asked the question, "but they often -- in fact, almost always, negotiate special prices, special negotiated prices; right?

"ANSWER: Prices that managed care negotiates with retail pharmacy providers has normally several levels involved in it. It's usually a negotiated discount off the cost of the medication plus a dispensing fee or a maximum allowable cost called MAC or usual and customary, and it defaults to whatever is the lesser of the three. So in some cases, it's possible that a managed care patient would pay usual and retail, usual and customary retail," period.

Do you see that?

A. I do.

Q. Okay. Do you see here where Mr. Bystrom is actually saying it's the lesser of the three, not the higher of the three, which is your testimony?

A. We're mixing apples and oranges again. MAC pricing relates to generics, not

brand.

Q. I understand that. He's -- but he's saying that it defaults to the lesser of the three, whether it's a negotiated discount off the cost of the medication plus a dispensing fee or a maximum allowable cost -- the first part relates to the generic -- I'm sorry, relates to the brand. The second one is how it works on a generic or usual or customary and defaults to whatever is the lesser of the three.

Does that refresh your recollection, sir, as to what Mr. Bystrom may have told you?

A. It didn't come up in this context and that was not the answer I recall --

Q. All right. Well, let me --

A. -- I asked.

MR. COHEN: I'd just like to interpose an objection. It appears that this -- that he's -- he's testifying about what managed care negotiates with retail pharmacies, not what somebody off the street would pay.

THE WITNESS: Right.

MR. DOBIE: No. He says it's the

patient. We're talking -- Jay, your example --

BY MR. DOBIE:

Q. What you said to me was is this somebody who has -- your -- your refinement on the hypothetical, is this somebody who has the benefits.

A. No. But what his answer is is the price that managed care negotiates with the retail pharmacy is the lesser of the three.

Q. The managed care patient would pay is usual and retail. All right. Let's -- let's try --

A. Did it say that? Where does it say that?

Q. The very last line, sir.

Let me show -- let me show you another document and let's -- we can move on.

A. But it doesn't say in that sentence what you alleged it to say. It says that "So in some cases, it's possible that a managed care patient would pay usual and retail or usual and customary retail."

Q. Right. The lesser of the three.

than the $25 copay for nonformulary products."

Were you aware, sir, that it was Duramed's understanding of the marketplace that, in fact, patients would, in fact, pay the lesser of the cash price or the negotiated price as opposed to the higher third-tier or nonformulary branded product price?

A. I had not seen this document before. I'm not sure that that's what they're alleging is that's the way the market works. They're making an artificial hypothetic as to how they price their product and what it would cost if they were charged -- if they were charging the retail on it.

Q. Did you read Mr. Finneran's deposition, for example, from Viking?

A. No.

Q. All right. Did you read Marty Carter, the head of managed care's, deposition from Duramed?

A. No.

Q. So did you know what the -- what their view is in terms of what they saw in the actual marketplace, whether -- how Cenestin was handled, whether it would be charged or whether

A. It doesn't say three. It says two.

* * *

(Whereupon, Gibson Exhibit 11 was marked for identification.)

* * *

BY MR. DOBIE:

Q. The document speaks for itself.

Let me show you a document, sir that you haven't mentioned as having been identified, so it may be the first time you're seeing it.

For the record, Exhibit 11 is a copy of a document that was produced by -- by Duramed in this case. Have you ever seen this document before?

A. Not to my recollection, no.

Q. Okay. This is a document that was identified as having been prepared by the folks that were involved in the managed care group at Duramed, and they have an example here of how a Cenestin script would be paid at retail, and if you look underneath the graph in the center of the page, it says, "In the above example, the actual cost of Cenestin to patient equals 15.74, since this is the amount" -- "since this amount is less

it, in fact, was -- was the charge that a patient would pay if they had a Cenestin script, whether they would actually be charged the lesser of the $25 copay or the negotiated price for the cash price?

A. No. Until this conversation, I didn't know their position.

* * *

(Whereupon, Gibson Exhibit 12 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Sir, I'm handing you what's Exhibit 12.

For the record, Exhibit 12 is a copy of a document prepared for the California Health Care foundation by Mercer Human Resources Consulting. We pulled this off the Web as well.

Mercer, sir, is a -- is a group you mentioned many times in your first deposition. You recall that?

A. I do.

Q. This is a group that advises health plans in terms of how to go about buying a

prescription drug benefit?
A. Right. Their primary -- their primary consulting practice is with the buyer.
Q. The buyer being a health plan?
A. Well -- or the employer. They're employee benefits consulting specialists.
Q. So if -- so if I'm an employer and I want to buy basically health insurance or self-insure, I might go to Mercer for advice on how to do that?
A. Uh-huh.
Q. And is this a group that has expertise in your view in terms of how common different types of arrangements are, rebate contracts, exclusives, things like that?
A. I think they would be knowledgeable, yes.
Q. Do they have a database that has information like that?
A. I don't know.
Q. There's a -- let me draw your attention to -- have you ever seen this document before?
A. I don't recall that I have. I've

seen a number of California Health Care Foundation documents, but I don't believe I've seen this one.
Q. Let me draw your attention to Page 15. There -- there's a discussion about usual and customary retail pricing.
A. My document only goes up to 9.
Q. It's in the lower right-hand corner.
A. Still going here.
Here we go. It starts at the top with contracts between PBM and health plans?
Q. Yes, sir.
A. Okay.
Q. And over on the right under "Usual and customary" --
A. Yes.
Q. All right. And the second sentence says, "When the usual and customary retail price is higher than the contracted price, the PBM pays only the contracted price. When the usual and customary retail price is lower than the contracted price, the PBM pays the usual and customary price." Do you see that?
A. I do.
Q. Do you have any basis for

disagreeing with -- with the statements by Mercer in this report to the California Health Care Foundation?
A. No.
Q. All right.
A. Are we done with this?
Q. Yes, sir, for the moment.
Let me ask you about your experience with pharmaceutical marketing. You have never marketed pharmaceutical product; correct?
A. Correct.
Q. And again, you've never worked for a pharmaceutical manufacturer, served on an advisory committee as it related to any issue whatsoever; correct?
A. Correct.
Q. And you've never taught pharmaceutical marketing?
A. No.
Q. Have you ever written any articles on pharmaceutical marketing?
A. I have written articles with issues of pharmaceutical marketing within them.
Q. And which of the articles that are

attached to your report have pharmaceutical marketing issues within them?
A. As I recall, the article that I wrote concerning the diminishing pharmacy benefit contained issues of marketing.
Q. This is the "Consumers can look forward to deductibles, generic drugs, and online Canadian purchases"?
A. No. That is -- that was my article dealing with why pharmaceuticals are cheaper in Canada, I believe, that -- that you're looking in Organized Labor?
Q. No. I was looking at your list of articles here, "The Diminishing Pharmacy Benefit."
A. Let's see. This was on -- yes, that was it.
Q. That is the article?
A. I think there was a tangential discussion about pharmaceutical marketing in that. And let's see. I'm not sure if the article dealing with "What Comes after Managed Care" had pharmaceutical issues. It dealt mostly with managed care and HMOs. I think those are probably the articles that might have some information

about pharmaceutical manufacturer marketing.
Q. Okay. And does -- does the preparation of either two -- those two articles in your view make you an expert to give an opinion on pharmaceutical marketing to a jury in this case?
A. I know -- I know how pharmaceutical marketing works, but I'm not -- I'll leave it to others as to whether I'm the expert or not.
Q. Okay. Well, do you -- do you yourself view yourself as --
A. I think I'm knowledgeable.
Q. If I could finish the question.
Do you view yourself as an expert in pharmaceutical marketing, having written two articles, one of which has a a tangential mention of marketing, to use your terms?
A. Again, that wouldn't be the only reason I would claim to be an expert or giving an opinion.
The involvement in the market on a daily basis, conversations both with the prescribing physicians and the dispensing physicians, and an overall reading knowledge of how the market works would be the pillars on which

I would render opinions.
Q. Okay. And what I'm asking is is whether that, talking to physicians and patients and having written these two articles -- whether you believe that that qualifies you to give an opinion as to pharmaceutical marketing as an expert.
A. Okay. That's a new question. The answer is yes. That wasn't the one you asked before.
Q. And why -- why do you think that you are an expert in pharmaceutical marketing based on your experience?
A. Because as with all the other issues we've been discussing today, I have a much more broad view of how the mosaic works. I have never claimed to have negotiated a rebate contract or marketed a drug or any of the other issues we've talked about. I do have the overview of how the market works and understand marketing's role in that.
Q. Is any -- is anybody -- well, strike that.
Is your expertise in pharmaceutical

marketing -- strike that.
Isn't it true, sir, that in this case, when you looked at the Premarin preemptive plan, which is a marketing document, you didn't even understand it and had to talk to Mr. Bystrom, who does have more experience, about it?
A. No, that's not correct at all. When we both first looked at it, neither of us understood it. We took -- it took us time to be able to really study that document to understand what all was in it. By the time we were finished, we both understood it.
Q. And -- and having read it, then you understood the -- in your view what Wyeth's marketing plan was as it related to Premarin and Cenestin?
A. I understood the Premarin preemptive plan. I don't know that I understood their entire marketing strategy, but I knew how they were using the various legs of the Premarin preemptive plan and how they were both rewarding and punishing people who behaved in fashions that were not consistent with what they wanted.
Q. Is -- is that -- that review of the

document that you made, is that -- is that something that if -- that if you showed it to a member of the jury, they could understand that as well, or Mr. Cohen?
A. I think I could show exhibits to the jury so they'd understand. Is that your question?
Q. No. It's a different question.
This -- this view that you have that the -- well, strike that. Strike that.
Is there any other marketing, pharmaceutical, or any other background that you have, sir, that qualifies you to give an expert opinion on pharmaceutical marketing that we haven't talked about?
A. We've been at this for several hours now. I think we've pretty well covered it.
Q. No. I'm talking about just as it relates to pharmaceutical marketing, which we've only been on for 10 minutes.
A. I think -- I think my most detailed view of -- of how marketing really works in the pharmaceutical sector was through the discovery documents within this case.
Q. Okay. Let's talk about the P&T

committee. We covered already your experience at PCN with the P&T committee in some detail. We covered briefly in your last deposition Omni, and am I right that Omni simply had a -- had a formulary that -- it was a -- it was a formulary that you obtained from Integrated through PCN?

A. Correct.

Q. And it was essentially a two-tier formulary?

A. As I recall, it was two-tier.

Q. And do you know whether or not products that were not in the second tier -- strike that.

There's -- there's different ways to have a two-tier formulary; right? You can have branded and generic. You can branded, generic, and then not covered. Do you know how it worked at PCN?

A. It was primarily generic versus brand. The only reason you would slip a brand into the first tier was if it was unique in class.

Q. So basically patients would pay a lower copay for any branded pharmaceutical at PCN; is that correct?

A. No. They pay a lower copay for generics.

Q. All right. They pay a lower copay for generics and then if it was a branded product, all branded products were on the -- in essence the second tier?

A. All of the branded products on formulary were on -- were on the second tier unless it was a unique product in class.

Q. All right. Here's what I'm trying to understand. There are -- there are some two-tier formularies when there is a generic and then there is -- everything else is basically considered covered except for certain exclusions, whether it's -- it's certain very high-cost products. There are other formularies that are two tier where you have a generic and then you have branded on formulary and then you have other things that are not reimbursed at all.

Do you know what was the structure of the two-tier formulary at Omni during the time period that you were there?

A. As I recall, if it wasn't on the second tier, it wasn't reimbursed.

Q. All right.

A. Without a prior authorization.

Q. And how often did the P&T committee of Omni meet?

A. It was fairly infrequent. As I recall, it was like once every six months.

Q. All right. And you were there 18 months, so maybe three meetings?

A. A couple of years. What are the dates?

Q. We went through that at the beginning. I think it was --

A. Okay. Whatever the dates on the -- on my --

Q. The earlier resume I think has the precise dates. Right.

A. Omni was '96 to '98. So it would be a couple of years.

Q. I think we did this earlier.

Let's look at Exhibit 4. You have May of 1996 through January of '98.

A. Yes. That would be the correct -- that would be the correct dates.

Q. Okay. And so how many times would

the P&T committee have met during that time period if they met every six months between May of '96 and June '98? Three or four?

A. As I recall, we had three or four meetings.

Q. All right. And do you know whether or not the estrogen class of products was reviewed by Omni?

A. I don't recall that it was.

Q. Did Omni keep minutes of its P&T committee?

A. I don't know. I believe we did.

Q. Were you the keeper of the minutes?

A. No.

Q. Do you know who was?

A. It would have been Steve Ondel, who was the chief of pharmacy benefit. He was a pharmacist.

Q. How many members were on the Omni P&T committee, if you remember?

A. It was a fairly broad group of physicians who were from various specialties and various locations within the Omni market. That would -- as I recall, it was around 15 physicians

and it consisted mostly of doctors from both Sacramento and Stockton.

Q. What was the staff's role at -- at Omni as it related to say what drugs go on formulary?

A. There -- there's a difference here between the formulary, the P&T committee at Omni and the P&T committee that's operational at a PBM level. Did you want to go into that?

Q. This is because you were -- you were basically using the Integrated -- you were working through Integrated and on to PCN?

A. Yes. There was -- this was an opportunity to primarily get buy-in from the prescribing physicians, that if, for instance, there wasn't a drug on the formulary that there was a strong feeling we should have it on the formulary, that there was a voice -- there was an opportunity for them to express themselves in that fashion. And if -- if that -- as I recall, it didn't arise, but had it arised -- arisen, one of the factors that the staff would bring back to the committee was the financial implications of breaking a contract.

Q. Okay.

A. Now, incidentally, in your own Wyeth documents, the company recognizes that this is a not uncommon trend to have independent P&T committees that have great say over what is or isn't on the formulary and part of their strategy in dealing with this was to --

Q. I just want to -- we'll get to -- we'll get to -- if you could just answer my questions, we'll actually get finished and I won't have to bring you back or go out to Sacramento.

* * *

(Whereupon, a discussion was held off the record.)

* * *

THE VIDEOGRAPHER: Proceed.

BY MR. DOBIE:

Q. Is what you're saying is that if there -- if there was a specific demand as applied to formulary, the P&T committee at Omni existed in order to basically have another voice to in essence tweak, to use your words, the formulary and make some additional product placements?

A. Yes, I think that's fair to say.

Q. And in the time that you were there, there was never an occasion where the staff was asked to make a -- some sort of a financial analysis of the implications of breaking a contract; right?

A. Not that I know of, but had that arisen, they would have been the one asked to do it.

Q. And at your time with the P&T committee at PCN for some meetings that you guys have had so far, have you ever had any communications with any of the staff members at PCN about the implications of breaking a contract with a -- with a pharmaceutical company?

A. No.

Q. Let's go back to your report, which is Exhibit 1, and if you turn to Page 12, you state that the primary participants in the distribution of pharmaceutical products are pharmaceutical manufacturers, wholesale distributors, retail pharmacies, mail order pharmacies, government agencies, physicians, and PBMs. Do you see that?

A. I do.

Q. Okay. How are PBMs distributors of pharmaceutical products?

A. If they own mail order --

MR. COHEN: Object -- object to the form.

A. If they own their mail order firm, they are part of the distribution chain.

BY MR. DOBIE:

Q. And what about in terms of understanding the chain of distribution; what are -- the customers, aren't they the end point of that, the distribution chain?

A. You're looking at the -- at the slide? Is that what you're looking at?

Q. The slide, your discussion here about the participants in the distribution system. I didn't see any mention of the customers.

A. Well, that's -- that's part of the fundamental problem within the health care market, is because so many rises, who is the customer? Is it the patient? Is it the health plan? Who's the customer here?

Q. So you didn't include the customer either. You didn't include the patient at least

as somebody in the distribution system. You don't -- you don't believe that they are, and that's a criticism of --

A. They --

Q. -- the --

A. They --

Q. -- system. Would you let me finish? Is that correct, sir?

A. The customer is relevant in the distribution system on cash payments, a cash-paying customer.

Q. So why didn't you include them in the distribution system?

A. Because they're the end user. They're not part of distribution. They receive the product at the end point.

Q. We were talking before about the chart that's on Page 13 that you got from Mr. Schondelmeyer, and I was asking about how comfortable you are with the data that's in there. In fact, where it says at the top "Private Insurance" and then there's a -- there's a little circle there, do you see that?

A. Uh-huh.

Q. It appears to show private insurance contracting with pharmacy benefit managers. Do you see that?

A. I do.

Q. And, in fact, isn't -- the truth of the matter is in most instances it's various employer plans, various -- as you mentioned, Taft-Hartley union groups and others that are the ones that are contracting with PBMs. It's not really insurance, is it?

MR. COHEN: Object to the form.

A. It's part of a basket. For instance, many times the insurance companies are administering these ERISA trusts and Taft-Hartleys. So a patient here in Philadelphia might be carrying in their pocket a card from Independence Blue Cross, but, in fact, they're just administering the benefit for the teamsters. And so the -- as the administrator, they frequently would be responsible for generating the contract with the pharmacy benefit manager, particularly if it's an internal captive.

BY MR. DOBIE:

Q. So it's -- there's a lot of

administrators that are out there that, in fact, deal with the pharmacy benefit manager and they might have helped administer the medical side of the equation along with the -- with the pharmacy benefit; correct?

A. There are two broad classes in this circle. One is a fully insured product like Blue Cross that is serving an ASO contract, which is administrative services only. And there is a second group, which would be the third-party administrators, or TPAs, and it's not infrequent in that environment that the consultant like Mercer would have a good deal to say about which PBM administers the benefit -- the pharmacy benefit for the underwriter.

Q. In the -- using your example before, the teamsters union, that's a Taft-Hartley-type situation. You used --

A. Right.

Q. -- another phrase. That would -- they would be a TPA in your definition?

A. No. They're not a TPA.

Q. What are they --

A. They are the underwriter. They

would fit in that circle, the private insurers, but they would be administered by a TPA that's serving as a contractor to the plan and they would contract with a PBM.

Q. All right. But if we're talking about the sources of payment for prescription drugs, at the end of the day, in the example that you used, the teamsters -- have you got a teamsters union -- they're the ultimate payer?

A. That's correct.

Q. All right. And do you know what percentage of the marketplace is, as it relates to pharmaceutical products, situations where it is -- the payer is a plan in essence versus what percentage of the marketplace is the payer, an insurance company that's basically taking a premium in exchange for -- for assuming the risk of the pharmacy benefit?

A. What you're -- I'm not quite sure of the answer. I will give you as close as I can give you to the answer to respond.

The size of the fully insured market, which would include the indemnity and the HMO products, compared with the self-funded

market, which would be the ERISA and Taft-Hartley, my bet is it's about two-thirds-one-third. I could easily get you that number. But I don't --

Q. Two-thirds-one-third which way?

A. Two-thirds fully insured, one-third -- and it varies by market. There are some markets -- take Hawaii, for instance, where there's hardly any ERISA trusts. There are other markets where there is -- a high percentage of the market is ERISA trusts. So it's a market-by-market issue.

Q. So it's your belief that in -- as it relates to -- let me -- let me see if I can refine this.

It's your belief first that two-thirds of the market is represented by fully insured or indemnity-type situations and only one-third is self-funded?

A. Are within this private insurance market circuit, yes.

Q. Okay.

A. And that again is just off the top of my head without having a reference that I could easily get for you.

Q. All right. Do you know whether or not that number changes as you go from general health care, in other words, for physicians and things like that, as opposed to pharmacy benefit? In other words, isn't there a greater proportion of folks that may go for full insurance as it relates to a health benefit, but when you come to a pharmacy benefit, that's carved out and they will self-fund that?

A. Carving out has been in the market for a number of years. It hasn't been a major trend. It exists. The general reason why self-funded and -- and Taft-Hartley trusts exist in any given market depends more on what is going on within the state. For instance, if you have an activist government that does a lot of mandated covered benefits, let's say reproductive services, within a given market, the incidence of self-funded, which is federal law, goes up.

Q. Let me ask you this, because this is -- the reason I was asking you this, if you go on to your report on Page 15, you state that "By 1999, only 8 percent of persons with employer-sponsored health insurance coverage had

traditional indemnity insurance."

What did you mean by that?

A. That's the old kind of insurance where you could go see any doctor you wanted, there were no fee schedules, you paid for service at the time of service, and you would submit a claim to the insurance company, and after you reached a certain deductible, you would start to get a percentage of whatever you paid back.

Q. Where did the other 90 -- where is this -- where does the other 92 percent fall?

A. Most -- most of it is explained on that chart here on Page 13. The 90 percent would be within the circle we were discussing on private insurance. They would have gone to managed care products, particularly HMOs, and then the balance would be in public insurance programs like Medicare and Medi-Cal and in -- in government programs of one sort or another like Healthy Family programs and then the final would be the uninsured, which would be the self-pay.

Q. Okay. In looking in -- at the pharmaceutical market, how it works, which is the discussion the first part of your report -- turn

to Page 40 of your report.

A. I'm sorry. Which page?

Q. Page 40.

A. 40. Okay.

Q. You've got a chart there that says "Follow the Money."

A. Uh-huh.

Q. "PBM play central role." And again, is this another document that you -- you downloaded from the Internet?

A. It's referenced right there where I got it.

Q. Okay. And did you just -- again just place it right into your report, make any changes to it that you recall?

A. Well, we're -- I suppose we're going to go over this issue of quotations marks. To me, sourcing the document is the common way to identify where I got that information.

Q. Okay. And you -- you believe it's accurate and authorative?

A. I do.

Q. And in this example here, you've got the pharmaceutical companies paying rebates to

PBMs. See that?
A. I do.
Q. And then the percentage of the manufacturers' rebates going to the HMO or employer plan on the one instance and then in the other instance, if it's a health plan enrollees, we've got price discounts for enrollees. Is that your understanding of how that --
A. I missed that last part of your question. I'm sorry.
Q. I'm -- look -- look at the -- well, let's break it down.
Is it your understanding consistent with the document that's in your report that a percentage of manufacturers' rebates are in turn paid to HMO employer plans?
A. It is.
Q. All right. And is it also your experience that PBMs contract with pharmacies for negotiated price discounts for their enrollees?
A. Correct.
Q. On Page 13 of your report -- let's go back to that -- you say that there's essentially two categories of pharmacy patients,

cash and third parties.
Do you know what percentage of patients are cash and what percentage are third party?
A. Well, it's indicated here that as of 1999 about 11.6 percent of the market was self-pay for a total of 16.7 billion.
Q. And how much is third party?
A. It would be the added or summated value of private insurance, public insurance, and government delivery.
Q. On Page 13 of your report, again talking about rebates, you say -- in the paragraph that is right before the heading "Establishment," you say, "In some cases, the drug manufacturer pays a rebate back to the PBM or MCO for specific drugs dispensed to their members that are on the PBM or MCOs' formularies"; right?
A. Correct.
Q. And then on Page 14, you talk about -- in the one, two, three, four, fifth paragraph down, you say that "PBMs also" -- "PBMs also enter into contracts to obtain rebates from manufacturers in exchange for placement on the

PBM's formulary"; right?
A. Correct.
Q. All right. And again, this is an area that you have no personal experience in?
A. Let me rephrase that. I have no personal experience negotiating these contracts. I never said that I had no experience with these contracts or their effect in the market.
Q. Well, the -- we've talked about the effect of the market and we can -- we'll cover that a little bit more. But the fact of the matter is is through your experience have you learned that this is actually a fairly common practice, for drug manufacturers to pay rebates to managed care organizations?
A. Yes, it is common to pay. The percentage is the issue. The fact that they pay part of the rebate initially -- okay. I won't.
Q. Is the answer yes?
A. The answer is they do pay rebates.
Q. And is it -- is it -- is it your experience that PBMs enter into contracts to obtain rebates from the manufacturers in exchange for being placed on the formulary?

A. Placement on the formulary?
Q. Yes.
A. Yes.
Q. All right.
Q. And --
A. And Wyeth's documents support that.
Q. All right. What Wyeth documents are you talking about?
A. We can go through your contracts if you'd like, but a placement on second versus third tier had different rebate amounts paid to the PBMs.
Q. So it's your belief that Wyeth's contracts pay rebates depending upon whether or not they put Premarin on the second or the third tier?
A. That and about 18 other variables, yes.
Q. All right. And do you know whether or not there's any rebates that are payable at all for simply putting Premarin on their formulary in any contract?
A. To put --
Q. Let me repeat the question.

A. You're going to have to --
Q. In this case, sir, are you -- are you aware of whether or not Wyeth paid rebates to any PBM or any HMO for putting Premarin on formulary?
A. Yes. Yes. We have multiple examples of where Wyeth paid rebates for being placed on the formulary.
Q. All right. And let me make sure I'm -- we're being clear on this.
One way to pay -- do you know what access rebates are?
A. I'm not -- explain the term and I'll --
Q. Are you familiar with the -- with the practice of pharmaceutical companies to pay access rebates or moneys to PBMs or managed care organizations in exchange for being placed on formulary?
A. I'm familiar with rebates being paid for being on a formulary, on a given position in the formulary.
Q. Are you -- are you familiar with the practice -- of the differences between paying

money for being placed on formulary as opposed to manufacturers paying money for particular plans achieving certain market -- certain market share --
A. Sure.
Q. -- objectives?
A. Yes.
Q. All right. How does -- how does that work in the marketplace, if you know?
A. Again, that's -- that's -- that's documented through the footnotes on Wyeth's own contracts.
You're referring to two kinds of rebate contracts. One is for inclusion on the market -- on the rebate -- on the -- on the formulary and the second is what would be a performance-based contract that reimbursed based on market share movement favorably towards Premarin and in other instances on a performance base the diminution of Cenestin's market position.
Q. Do you -- do you know in this case, sir, whether or not the -- or whether in the industry, whether market share performance rebates are common?

A. Market -- yes, my -- my understanding is that it's common and is more common now than it used to be that rebates are tied to performance.
Q. Right. Do you know whether simply obtaining -- how do you know that?
A. Again, it's the discussion you and I have had up till this point where I have had the opportunity to talk with individuals in the industry about it.
Q. Okay. And who are -- who are the individuals, sir?
A. Same cast of players that I gave to you --
Q. Mr. Scull.
A. -- for the -- yes.
Q. The pharmacist. Mr. Bystrom.
A. And Mr. Bystrom would be the chief of -- that I would have as my sources.
Q. All right. And then the practice of paying rebates for simply being on formulary as opposed to hitting certain market share targets, is that practice common in the industry?
A. I think both are common in the

industry. I think, though, that it is a moving picture, not static, that the -- that the issue of performance-based rebate contracts are much more common today than they were five years ago.
Q. Do you know how many manufacturers today use performance-based rebates as opposed to simply rebates for putting you on formulary?
A. My -- my -- my understanding is almost all of them use performance-based rebates.
Q. Okay. How about five years ago, 1999?
A. Five years ago, it wasn't as common. It was more common to be placed, because on a second-tier arrangement it was -- you know, if you're on the formulary, you're -- you -- that's what you wanted. If you're in a three- or four-tier structure, the client has -- or the patient has access to the third tier. Then it becomes an issue of how you structure the plan as far as the amounts of the co-pays for the different tiers and whether you put in place negative factors like prior authorization, which Wyeth demanded on a number of its -- wrote into a number of its contracts, which would be a reason to increase the

rebate, because it moves market share.
Q. Do you know whether Duramed sought performance rebates from any PBMs?
A. I do not.
Q. Do you know whether Duramed sought access rebates from any PBMs?
A. Again, I do not know.
Q. In assessing what impact Wyeth's rebate contracts may have had in the marketplace, does it matter to you at all what type of agreements or whether or not Duramed was seeking to have rebate contracts itself?
A. My opinion -- good question. The answer is that we're talking apples and oranges. Wyeth is apples. Duramed is oranges. It's one thing to be in a dominant position with a MCO or a PBM relying on the revenue from your existing contracts and a new player. And so I don't think understanding Cenestin's strategy or rebate structure made much difference, and I illustrated that in a -- in a graph.
Q. Would it -- would it matter to you at all in terms of if Duramed did not actually seek a formulary position in any managed care

organizations? Would it matter to your opinion?
A. Yes, it would matter to my opinion.
Q. How so?
A. Again, you're -- you're good at creating hypotheticals that are hard for me to grasp.
Q. Let me -- let me -- let me say it broader.
Does it -- would it matter to your -- I mean, you told us you're not aware of what type of rebate contracts Duramed did or didn't offer to -- to managed care organizations; right?
A. What I'm saying --
Q. Yes or no.
A. All right. Yes, it would make a difference.
Q. Okay. And so it would make a difference if Duramed, in fact, did not go out and offer PBMs a managed care agreement, their own managed care agreement, in terms of why they were or weren't on formulary?
A. Yes. It would surprise me if a -- if a sophisticated marketer like Duramed would

bring a new product on the market and completely ignore the rebate issues.
Q. All right. Would it surprise you if you learned that Duramed decided not to seek formulary position at certain managed care organizations?
A. Well, it depends on the managed care organizations. I mean, it's one thing not to go for it on a dominant player like HealthNet in California, and it's quite another to go for a marginal player in California like, say, CIGNA.
Q. Right. So would it be -- would it surprise you or would it be important for your opinions to learn whether or not Duramed did, in fact, seek or not seek formulary placement with major managed care providers, PPMs and HMOs?
A. I think that would be helpful to know.
Q. All right. And -- but to date, you have not undertaken that inquiry?
A. No, I really haven't.
Q. Oh. I asked you a question in your last deposition about whether or not it was common to have rebate agreements with Medicaid or Medi-

Cal plans. Do you recall that?
A. I don't recall that, but I'm not surprised that we discussed it.
Q. All right. Because, in fact, PCN has a lot of Medicaid and Medi-Cal type plans that it adminstered historically; correct?
A. Correct.
Q. And you're familiar with that?
A. Correct.
Q. Are you familiar with the fact that PCN, in fact, does -- that there are rebates that are earned in connection with products that are on formulary, Medicaid and Medi-Cal formulary?
A. I'd be surprised if they didn't have rebates on brand products.
Q. And when did you learn that, sir?
A. When did I learn they had rebates?
Q. Yes.
A. I didn't learn that. You -- you asked me whether I'd be surprised, and I was saying that I wouldn't be surprised, that you would not leave money on the table.
Q. So is it -- is it your understanding -- did you know -- do you know

sitting here today whether the plans -- Medicaid or Medi-Cal type plans receive rebate dollars?

A. My assumption is they do, but I don't know it and I haven't seen the contract.

Q. Do you know whether or not a hundred percent of the rebate dollars are as a general matter passed on to Medicaid and Medi-Cal plans by PCN?

A. They -- it is passed on -- not a hundred percent, but it's passed on by PCN. PCN is noted in the industry as one of the most transparent PBMs and passes through some of the highest percentages within the industry of rebates. But it's not a hundred percent. Usually it's 80-20, I believe.

Q. Have you ever seen your form contract?

A. No.

Q. Have you ever had a discussion with your pharmaceutical contracts administrator about that?

A. Yes.

Q. And did they -- did they tell you that they had a template?

A. They -- they told me that in -- that the number I just gave you on a 80-20 split is what they usually put into the contract, but I have not seen the contract.

Q. When did you have the discussion?

A. Again, this is over the course of the past year and it would have been with the players that I've identified, plus Sue Navis was the network provider for the pharmacies, and the chief of the professional services division at PCN, which -- which was Amy Chin, as I recall, told me about that.

Q. Okay. So in the 80-20 -- here's all I'm trying to understand. Do you have any understanding as to the difference between what the PCN contract template, what your typical contract is when it's a Medicaid-Medi-Cal plan on the one hand versus on the other hand a private plan?

A. In general, it's consistent across the board, is my understanding, that PCN passes through the majority of the rebate to the client.

Q. And -- and you said 80 percent of it in the instance of -- of a private plan. Do you

know what it is if -- if it's a Medicaid or a Medi-Cal plan?

A. It's for both.

Q. All right. That -- that was my question.

A. However, the percent of rebates in the Medi-Cal are lower because there's a much higher percentage of generic on the formulary.

* * *

(Whereupon, Gibson Exhibit 13 was marked for identification.)

* * *

BY MR. DOBIE:

Q. Let me show you what we marked as Exhibit 13.

For the record, Exhibit 13 is a document produced by PCN's contract manager in response to a subpoena that we served as part of the preparation for this deposition, and as you -- as you can see here, she says that in Pharmaceutical Care Network their boilerplate contract is 80-20 rebate split on the commercial business. And then she's got another boilerplate on the managed Medicaid accounts as well.

Sir, if I turn your attention to the very -- the last page of the document.

A. Are there two documents here or one?

Q. It's -- I think I can walk you through it. Go to the very last page of Exhibit -- Exhibit 13. Exhibit 13 is just a single page that differs from the prior contract and -- go to Paragraph 6.7.

A. On -- on the last page --

Q. Yes, sir.

A. -- of the exhibit?

Q. And you'll notice that --

A. 6.7, it starts, "PCN will collect"?

Q. Uh-huh.

A. Okay.

Q. And then the second sentence says, "PCN will remit to payer 90 percent of the reimbursement savings collected by PCN." Do you see that? "The balance" --

A. I do, yes.

Q. -- of the reimbursement savings collected, 10 percent, will be retained by PCN in consideration of the performance of its obligation"; right?

A. Correct.
Q. And then if you go to 6 point --
A. Now, is this -- is this part of this document or is this part of another document and this is the only page from it?
Q. This is -- this is the only page -- I think that your Medicaid boilerplate contract is what --
A. Okay. And the other one is the commercial?
Q. Yes, sir.
A. Okay.
Q. But -- I guess the question that I have for you, you've never seen either one of these documents before?
A. If I have, I don't recall it.
Q. And turning to Paragraph 6.7 of the first contract.
A. That would be on Page 9 again?
Q. No. 5 of the -- of the document.
A. Okay. Yes.
Q. It notes that PCN will remit to payers 80 percent of the reimbursement savings collected by PCN and the balance of the

reimbursement savings collected, 20 percent, will be retained by PCN in consideration of the performance of its obligations.
A. Right.
Q. Right. And sir -- so generally speaking, at least at PCN, I assume that we can agree that the rebate dollars that are collected by PCN are passed on in the vast majority of instances to the plans, whether it's a Taft-Hartley or an ERISA plan or something else?
A. At PCN, yes.
Q. And -- and by -- by these rebates being passed on to those plans, if it's a -- let's say it's the teamster union, it lowers the teamster union's cost for the pharmacy benefit that it provides to the members; correct?
A. Not necessarily.
Q. Doesn't -- doesn't PCN's passing on of the rebate to the -- to the union or whoever it's administering the benefit for lower their cost over what it would otherwise be for the pharmaceutical product?
A. Again, not necessarily.
Q. Okay. And why not?

A. If you incentivize, through a rebate structure, the use of a -- of a brand product when a generic is appropriate, you're increasing the cost to the client.
Q. Well, in -- at PCN, is that what you're doing? Are you incentivizing people to use generics or are you incentivizing them to use branded?
A. And are we talking -- at PCN, in both the commercial and the Medi-Cal, we would be encouraging the generics.
Q. Okay. So --
A. Which is not the norm in the industry.
Q. But I'm talking about PCN.
A. Got you.
Q. So at PCN --
A Which is -- which also is just a minor player in the industry.
Q. At PCN, generally speaking, it would generally be the case that passing on of the rebate dollars, 80 percent of them or 90 percent of them would lower the cost to the particular employer plan or union plan that's paying for the

health care; right?
A. You've -- you've -- you've built walls around this, and the answer to that is yes.
Q. I'm not trying to build walls around it. I'm talking about PCN.
A. Yes.
Q. Which is -- because that's where you work; right?
A. That's right. It's a small plan and it's unique in the way it administers the benefit.
Q. All right. But it's where you work and it's where you have your experience; right?
A. Well, I've got experience beyond that.
Q. I understand that.
A. But yes.
Q. All right. But it's a significant part of your experience and that at least at PCN these rebate dollars that are paid would lower the cost to the particular plans; right?
A. Yes.
Q. Okay. Now --
MR. COHEN: Gordon, excuse me. I have a request. I know these -- this PCN

document is from the subpoena that you issued against PCN. I made a request to counsel for PCN to get served with whatever they served you with, and I never got a copy. So I would just make a request that any documents that you -- you received, that I get a copy of that.

MR. DOBIE: I actually thought he was going to bring them today. That's what she told me.

MR. COHEN: We never received that.

MR. DOBIE: The last I talked to her was Friday afternoon, Jay, after you and I spoke and -- well, over the weekend I was on a Boy Scout trip with my kids and then getting ready for a deal yesterday in Florida on Sunday and Monday. And so we got this in at some point over the weekend. And that's it. That's the only document.

MR. COHEN: This is the only document? And --

MR. DOBIE: I've asked her for others and she promised that she would provide others.

MR. COHEN: We haven't heard from her.

Can I ask you -- this seems to be -- the page numbers are out of order. Did you extract any pages from this or did they do the extraction?

MR. DOBIE: She -- she sent us an e-mail that had those documents and that cover letter and nothing else.

MR. COHEN: So when it goes from Page --

MS. WARD: And I'll represent that there were two attachments to the e-mail and it's referenced in her e-mail that says -- she says it's boilerplate with a Word document, which is the first document I attached to the e-mail, and that's a sample contract. And the second page -- or the final page of the exhibit --

MR. COHEN: The Page 9?

MS. WARD: Right. Was a PDF of one page, and she represented in the e-mail that "I've included it" -- well, there's a typo, but "a copy of the page from one of our

managed Medicaid agreements so that you can see the difference."

MR. COHEN: So I have what you have.

MR. DOBIE: You've got it.

MR. COHEN: Okay.

MR. DOBIE: But I'd like to get some more. I was hoping -- but that's all we've received.

BY MR. DOBIE:

Q. Okay. And then -- sir, let me ask you this: Have you read the depositions of any of the executives from Medco that were deposed in this case?

A. I may have. I would have referenced it in my footnotes if I had used it.

Q. Okay. It's --

A. And you've got a list of the documents --

Q. Yes.

A. -- that I --

Q. It's not either on your list of documents and it's not in your -- any of the footnotes. So is it safe to say that you haven't read either of the depositions of the Medco

executives?

A. I think so. I'll qualify it that I could be wrong, but I don't think so.

Q. Well, they weren't deposed in the Duramed case, so -- Mr. Cohen pointed out before there may be things that you saw in Duramed, but they weren't deposed in that case.

So the only documents that you would have reviewed were the documents from the Duramed case, the materials that are cited previously in your --

A. Correct.

Q. -- in the exhibit as well as in your report; right?

A. Right.

Q. And would you have wanted to know that at Medco, in fact, Premarin rebates were passed on to health plans at between 83 and 90 percent of the time between 1999 and 2002?

A. That's interesting news. However, the rebates can take many forms. In other words, you can have, as we discussed, positioning and -- and performance rebates. There's also administrative rebates. I don't know if that's

included in that number or not. And there's a whole separate rebate structure for mail order.

Q. Well, let me -- let me show you a document here that's been marked as Odansik 1, and it discusses the two types of rebate dollars that Medco received from Wyeth, and Mr. Odansik and the other executive from Medco, Mr. Narden, testified concerning Medco and the pass-on of rebates and testified under oath, like at PCN, that they pass on rebates at between 80 and 90 percent of the time on Premarin. Not on every product, but on Premarin.

A. So the first line here -- not -- the first line is the date, but the first line is the base formulary rebate pass back is 91, 83, 88, 90, and 88?

Q. Yes, sir.

A. And what's the second line?

Q. Those are incentive rebates and those are generally, as you indicate -- as indicated here, is only 2 percent passed on.

A. Now, are these -- is this a summated number, so that 91 plus 2 percent?

Q. No. The incentive rebates, those

are -- the witness testified that to the extent that a plan achieved performance over -- above the national market share of some very high percentage, a percentage that rarely, if ever, was hit by Medco, hence the Cenestin amendment and so on, those rebates would only be passed on in -- at -- by contract at 2 percent of the time.

A. So that's 2 percent of the total rebate that they got --

Q. Yes?

A. -- or what does that mean?

Q. That would be that by contract they would only have to pass on --

A. 2 percent --

Q. -- 2 percent.

A. -- of the performance rebate.

Q. If they ever hit the high -- no, not of the performance rebate. If they hit certain tiers.

So if it's a contract that provides that we will pay a rebate to the extent that the plan is 5 percentage points over national -- let's just use that as a -- as the example. All right. If Medco was successful in achieving that type of

performance through all sorts of activity, whipping up action of physicians and sending out their own folks, if they were able to achieve that, that was a rebate dollar that Mr. -- Narden and Mr. Odansik said they, pursuant to their agreements with their health plans, could keep that.

A. Okay.

Q. But -- but -- let me just finish.

But the top number is the number that was actually where rebates were -- generally came in. In other words, if -- if you were within zero to 2 percent of national market share or zero and 3 percent -- and I'm using the numbers loosely, but -- but essentially the vast majority of Medco plans would have never hit the higher threshold, the incentive rebate passback.

A. Okay.

Q. So he testified that, in fact, 90 percent of the rebates on Premarin were passed on. All right?

A. Well --

MR. COHEN: I'm just going to interject an objection to the form to the

extent that the transcript is being characterized, that the transcript speaks for itself.

MR. DOBIE: That's fair.

BY MR. DOBIE:

Q. But let's say hypothetically 80 to 90 percent of Premarin rebates were, in fact, passed on by Medco to the health plans.

Is this the first time that you're hearing that today, sir?

A. Yes.

Q. Would that have been relevant to your opinions?

A. It would be more relevant if I had the rest of the chart.

Q. Okay. There's nothing else to the chart.

A. Well, there's more rebates than this. That may be all you've got on the chart.

Q. This is all that Medco produced in this case.

A. Well, I'm just saying there's more rebate structure in your own documents --

Q. Why --

A. -- how Wyeth contracted.
Q. No, I'm not talking about how Wyeth contracted. I'm talking about between Medco and the health plans. All right.
Assume -- you can view this as a hypothetical. Assuming that the testimony -- the undisputed testimony is that somewhere between 80 and 90 percent of Medco's rebates are passed on to health plans, that might impact your conclusions, would it not, in terms of the benefit of rebates on the Premarin product; right?
A. I don't think I'm articulating my problem here. All right.
If that -- if this were the totality of the rebate structure, this would be helpful. It is not. The rebate structure also contains administrative fees which are well known in the industry, and Medco's one of the most aggressive players in that, and they are -- there are rebate structures that exist for mail order, and Medco's one of the most aggressive players there. So you've got -- as this sits here for me, substantial portions of the rebate dollars aren't accounted for.

Q. Have you made any effort, sir, to figure out whether or not -- the amount of Wyeth rebate dollars paid to Medco versus the amounts of administrative fees?
A. All I know is the contracts that we obtained through discovery and how those broke out.
Q. Okay. You -- you never -- Mr. Cohen or no one else ever sent you any information that explained how rebates were, in fact, passed on by Medco to the health plans and its clients?
A. Not that I recall.
Q. If, in fact, Medco did pass on between 80 to 90 percent of the rebate dollars that it received from Wyeth and --
A. In total.
Q. In total. And the administrative fees that they received from Wyeth were less than 1 percent of the rebate dollars that they received, wouldn't it be a situation much like what you believe the situation to be at PCN?
A. It would. I don't -- I find it not credible, but it would.
Q. Okay. Let's go to another example.

THE WITNESS: Can we take a quick break?
MR. DOBIE: Sure.
THE WITNESS: I've been consuming a lot of water.
MR. DOBIE: Okay.
THE VIDEOGRAPHER: Going off the record. The time is 5:01 p.m.
This is the end of Tape No. 3. The time is 5:02 p.m. We're now off the record.
* * *
(Whereupon, a short recess was taken.)
* * *
THE VIDEOGRAPHER: This is the beginning of Tape No. 4. The time is 5:12 p.m. We're back on the record.
BY MR. DOBIE:
Q. Dr. Gibson, have you reviewed the deposition of Blue Shield of California --
A. No.
Q. -- Lee Sagapi?
Q. Did you review the deposition of Express Scripts?

A. No. I did review some of the Express Scripts contracts.
Q. Have you reviewed any of the documents that have been produced by any of the PBMs in this case that address the issue about how much rebate dollars are being passed on to health plans?
A. These would be in the depositions?
Q. Yes, sir.
A. The only deposition -- we'll make this easy. The only deposition I have read was my old deposition. I believe in the Duramed case -- I don't know if I read Bystrom's deposition or not. But those were really the two depositions I've read.
Q. All right. And wouldn't you want to review the testimony concerning how much rebates are passed on in order to reach the conclusions that are in your report if you, in fact, knew that there was such evidence?
A. I wanted to know what the rebate structure was between the manufacturer and the PBM. That was my primary interest.
Q. And so you weren't interested to the

extent to which rebates were passed on between the PBMs and the health plan sponsors?

A. I did not look at that.

Q. Okay. And you weren't interested in it?

A. Not particularly.

* * *

(Whereupon, Gibson Exhibit 14 was marked for identification.)

* * *

BY MR. DOBIE:

Q. One of the documents that you did cite in this case I've marked as Exhibit 14.

MR. COHEN: Shouldn't this be 15?

MR. EINHORN: I think the other one was marked 14.

MR. DOBIE: I'm sorry. Oh, we didn't mark it? I just use the Medco -- okay.

MR. COHEN: Okay. I thought it was marked. I'm sorry.

BY MR. DOBIE:

Q. For the record, Exhibit 15, sir, can you identify for the record?

A. Yes. It is a -- it is a presentation set of slides from the GAO dated June 26 of 2003 and it deals with the subject of pharmacy benefit managers.

Q. So "The Role of Pharmacy Benefit Managers in Federal Employees' Health Benefits Programs" is what it's entitled?

A. Right.

Q. Did you attend this meeting, by any chance?

A. No.

Q. And where did you get this document?

A. As I recall, I either found it through a reference or I picked it up directly off of a search on the Internet.

Q. Can I draw your attention to Page 9, if I could.

A. Okay.

Q. All right. And this is a document that you cited in your report; correct?

A. The slide part of it?

Q. Yes.

A. Yes, it is.

Q. And -- and you note -- or it notes

here in the report that, in fact, from 1998 to 2001 rebates that PBMs paid to the three Federal Employee Health Benefit Programs effectively reduced plans' annual spending on prescription drugs by 3 to 9 percent. Do you see that?

A. I do.

Q. All right. Did you reference that in your report in any way?

A. No.

Q. And why not?

A. Because it is a complex number to arrive at.

Q. All right. Did you think this -- this was a reliable source for other purposes?

A. I did. And I think that's a reliable number, but it doesn't give you enough information to really answer it -- or to use it.

Q. Then don't you think as it relates to the people who are members of the Federal Employees' Health Benefit Program to see that rebate dollars paid by PBMs to them reduce their annual spending on prescription drugs 3 to 9 percent?

A. It --

Q. Isn't that a -- isn't that a useful piece of information?

A. It's an interesting piece of information. It's a useful piece of information. It, however, is one dimensional in least a three-dimensional world.

Q. Do you understand whether or not the same way that PCN passes on 90 percent or more of its rebate dollars to Medi-Cal in California plans, whether or not the -- whether the other PBMs, the major PBMs in the country, Express Scripts, Medco, AdvancePCS, and others, whether they, in fact -- they pass on an equally high percentage of their rebate dollars?

A. They do not.

Q. How do you know that?

A. That -- that is -- the best source that I would give you on that -- and I don't have the reference and I didn't put it in my document -- was about two or three years ago the then president of AdvancePCS gave an address to a trade convention, a national trade convention. He showed -- and this has never been published -- a graph with two Y axes. On the X axis was time by

year and on the first Y axis was revenue generated by -- by service; i.e., administering the benefit plan and processing claims and all of that sort of thing.

On the second Y axis was the percentage of revenue based on rebates.

The two graphs intersected with the -- in the earlier years, back in the early '90s, the majority of the revenue for the plans -- for the PBMs being generated from servicing the account to very little of the revenue coming from servicing the account, with the percentage of revenue coming to the PBM from rebates going in the opposite direction.

Q. Do you know how they account for rebate dollars, how a pharmacy benefit manager accounts for -- do they -- do they take the rebate dollars in in revenue in the first instance, record that as revenue, and then account for it differently as they pass it on to health plans? Do you know how they do it as an account?

A. I would think they probably all have different accounting rules.

Q. The --

A. I can look at their annual statement and then you could say.

Q. Are you assuming, sir, that because a high percentage of their revenues are rebate dollars that that means that they don't pass on a high percentage of the rebates to plans? Is that an assumption?

A. I don't think they're as high as you -- the question you asked was do I think that their rebate dollars and percentages are as high as the percentages that you find with -- with PCN's.

Q. To federal employee health plans.

A. Yes, but understand what I'm saying. It's a complex way in which rebates are accounted for. And your client is playing heavily in this market with more and more of the rebate going to administrative fees and to the mail orders. The reason for going with higher administrative fees is it gives them a way of getting around the 15 percent number that is the upper limits -- roughly the upper limits for rebate contracting with commercial accounts, because it would affect the Medicare and Medi-Cal rates.

Q. We'll come back to the Medi-Cal and Medicare reimbursement.

Do you -- but since you raise a different point, which is -- has to do with -- with Wyeth's contracting as it relates to administrative fees, do you know whether or not Wyeth pays administrative fees or any other rebate dollars to PBMs at any greater or lesser amount than owner pharmaceutical companies?

A. No.

Q. Do you know --

A. I know that -- I know that the general range, they were in it, which is somewhere between 2 and 5 percent.

Q. Okay. Do you know, for example, at Express Scripts what amount of nonrebate revenue Express Scripts received from Wyeth?

A. Nonrebate revenue?

Q. Yes, sir.

A. Well, if you -- if you -- if you classify rebate in the broadest sense like I just did, both revenue for placement on the formulary and positioning, revenue on rebate for -- for performance, and all of the other things that I've

cited in my contract, plus administrative rebates, plus mail order rebates, if -- if I'm answering within that context, are you asking me how much other things they pay?

Q. What you're saying is that there's a class of rebate dollars -- or it's a class of dollars that's paid to the managed care -- to the PBM that's not passed on; correct? That's your point?

A. Right.

Q. All right. Do you know what percentage Wyeth paid to Express Scripts that was not passed on --

A. No, I don't.

Q. -- to health plans?

A. I know that, for instance, what you just gave us here on Medco, which I find not credible. But no, I don't.

Q. All right. And do you -- do you know -- would you be interested --

A. And actually, there -- there would not be any reason that anyone would know that. That's not -- that's not published.

Q. Okay. Well, you're an expert in

this case. Did you ask --
A. Yes, but this -- these are proprietary things. Just because you're an expert doesn't mean you know proprietary information.
Q. Let me finish the question.
Did you ask Mr. Cohen to review the Express Scripts documents or the depositions to see what portion of their revenues that they received from Wyeth were passed on?
A. No, I did not.
Q. Did you ask to review what portion of the revenues that they received from Wyeth were rebate dollars that were passed on as opposed to administrative fees or other things that were not?
A. I confine my interest to what the contract was between Wyeth and Express Scripts and what those rebate structures were.
Q. Okay. But you've made assumptions in your report that there are certain fees that these managed care companies are -- are receiving from pharmaceutical companies like Wyeth that are not being passed on. So why would you not have been interested in seeing whether, in fact, a major PBM like Express Scripts was, in fact,

receiving rebate dollars that were passed on?
A. I knew that they were passing it on. I didn't know, you know, whether it was 50 percent or 60 percent or 70 or, as they allege here, higher.
Q. All right. Why would you not have been interested in what percentage of revenues that Express Scripts received from Wyeth were rebate dollars that were passed on versus other fees that were not?
A. Because it's not the primary area of my report. My report's primary interest was how these rebate structures changed the market, not the amount of money that was saved by the PBM or passed on to the third-party payer. That would primarily be the area of interest for those testifying for economic issues within the plan.
Q. Because you'd agree that certainly if you were looking at this from an economic matter, you would have to understand those issues?
A. I'm not an economist. I don't know what an economist would need.
I know, though, that my primary interest was did they have rebates, how were they

structured, and how did they affect the market.
Q. Okay. And -- and I guess what I would ask is, how can you say how they would affect the market, which includes patients, physicians, health plans, all of these other groups that you say are part of the market, without understanding how much those Wyeth rebate dollars on Premarin were, in fact, passed on?
MR. COHEN: Objection. Asked and answered.
A. Because you have to understand how the MCO or the HMO treats the rebate that comes back in. In other words, frequently it's not carried on the books as a part of ongoing operations. They're treated as one-time infusions of cash that are not part of the budget.
I know at Omni that's how we treated the rebates.
BY MR. DOBIE:
Q. You treat it as one-time infusions of cash?
A. These -- you couldn't budget and count on it, so it was generally carried not as a budget revenue but as one-time transactions on an

annual basis.
So I think the premise you're making -- I don't want to put words in your mouth -- is that these rebate dollars going back somehow go back into the benefit of the payer, and I don't -- I don't think that's consistent with the market.
Q. Okay. And all I'm asking is is you're saying that you don't think that that's consistent with the market, but you haven't made a study of whether it did or didn't happen in this case, have you?
A. No, I haven't.
Q. Let me ask you about PBMs more generally and the business. On Page 41 of your report --
A. Are we done with this?
Q. For that page, yes, sir.
A. Okay. You said 41?
Q. Yes.
A. Okay.
Q. It's a headline, "Rebates now represent" -- you see that? In the third paragraph, you state that "As the PBM" -- "PBM

industry competes aggressively for new clients" -- let me just stop right there and ask you about that first -- that first part.

Is it your understanding that -- that PBMs do aggressively compete for new clients?

A. I do, yes.

Q. And so health plans would go to various PBMs, whether it's -- it's your company, PCN, or Express Scripts or Medco or these others, and try to get the best deal that they can for a pharmacy benefit; correct?

A. Yes.

Q. And if the -- if the PBMs did not receive rebates or other administrative fees, do you think -- in your experience, would that impact what the PBM charge the client health plans and MCOs for their services?

A. You bet. They can't operate on no revenue.

Q. All right. And that the health plan's cost in essence would then increase?

A. That's a complex assumption. If -- if the --

Q. Well, you said they can't operate

with no --

A. I said the PBM cannot operate with no revenue.

Q. Right.

A. Let me describe to you what the typical competition is like.

Q. Let's -- we can do that in a little bit, but can you just answer my question in terms of whether the health plan's cost would increase in your experience if the PBM did not pass on -- if the PBMs didn't receive rebates or administrative fees?

A. The cost for the -- the cost for the administration of the health -- of the pharmacy benefit would probably increase. The overall cost of the pharmacy benefit might drop, which is what's really important.

Q. Why do you think that?

A. Again, it goes back to the function of if you set up the product so that there is a hundred-dollar branded product and a $20 generic product and you incentivize the movement of the market to the hundred-dollar product and then give a $10 rebate, you've increased the cost of the --

of the pharmacy benefit.

Q. Okay. And is that how PCN does business?

A. That's not how PCN does business.

Q. All right. And at PCN, is it true that the receipt of rebates and administrative fees actually lower health plan costs to the --

A. No, it's not. That's the point I'm trying to make here, but you keep limiting my ability to respond.

PCN, because it does an 80-20 split or better --

Q. Right.

A. -- charges for its administrative services. When we go into -- and I've been to these marketing meetings when the Merck-Medcos and the Express Scriptses come in -- they offer to give those services away free.

Q. And so they actually charge lower rates to health plans than PCN?

A. They do even better than that. They'll come in and they'll offer a cash bonus to get the business up front, which is some percentage of the rebate up front.

Q. And -- and these health plans that are out there, the teamsters union, and so on, that -- that we talked about, are they now frequently advised by groups like Mercer that we talked about, groups like that?

A. The world is a very complex place.

Q. Just generally.

A. I'm going to tell you that the Mercers do advise. I'll leave at that, and if you want more, I'll give it to you.

Q. Do you think that -- is it your experience that health plans are more often than not -- do they have a consultant that they're working with to advise them in connection with establishing a PBM benefit?

A. Most of the self-fundeds do. The large players like HealthNet, probably not.

Q. All right. And is it your experience that these consultants that would be helping health plans would have more than one client?

A. Sure.

Q. So they would have reason to -- to not only have visited with a company like yours,

like PCN, but in the past have talked to Express Scripts, talked to Medco, talked to the other PBMs that are out there offering a pharmacy benefit; right?

A. Yes.

Q. All right. So from that experience, they would be in a position to advise their clients in terms of which plan is offering the best deal as it relates to administrative costs, rebates, and other charges, right, at least in their -- in their view?

A. In their view. However, many of those organizations also have the PBMs, the large PBMs as clients.

Q. And -- and so that's another conflict in your view?

A. You bet.

Q. Okay. And which are the -- which are the conflicted advisers that -- that you're referring to?

A. Almost all the big houses.

Q. Is Mercer a conflicted --

A. As an example.

Q. Are they -- who are they conflicted

by in your view?

A. Well, their -- they have as a client all of the big top-tier PBMs and they are functioning as a consultant to their clients, who are the employers.

Q. So their clients include, let's say -- do they include PCN?

A. No, no. Their clients would be, you know, the -- a school district or a paper company or something like that.

Q. So the -- and now the PBMs, do they have -- you're saying that they have a financial arrangement as well with a group like Mercer?

A. They have -- they have a client relationship wherein Mercer helps them design their -- their offering to the market and there's a relationship.

Q. So -- so does Medco, for example -- do they use Mercer? Do they pay Mercer money?

A. Sure. They're a client of Mercer's.

Q. And Express Scripts?

A. Yes.

Q. They pay Mercer money. AdvancePCS would be paying money?

A. AdvancePCS, yes.

Q. And does PCN pay Mercer money?

A. No.

Q. So these other PBMs, they're out there in your view creating conflicts --

A. I don't --

Q. -- so that the -- so that --

A. I don't know that they're a conflict. There is a conflict whether it started by Mercer or them. I think most reasonable people would think there's a conflict.

Q. So in your view, the health plans then are not being appropriately advised by Mercer because of the conflicts with the PBMs?

A. I think the advice they get is highly likely to be influenced by the extracurricular relationships that they have.

Q. These conflicts that you're talking about, is it your view that these are rampant in the industry?

A. Yes.

Q. And -- and the advisers that are all out there are on the payrolls of the PBMs?

A. I didn't say that.

Q. Well, is it -- is it your view that a vast majority of them are?

A. I think that they have client -- the larger consulting houses, particularly Mercer, has client relationships with the top-tier PBMs.

Q. Do you think that most of the -- most of the plans that are receiving consulting advice in terms of their contracts are getting advice that is tainted by conflicts?

A. I just -- I do not know the answer to that. I think that it's an environment that's highly likely to be influenceable.

Q. All right. Have you ever quantified this in any way?

A. No, I have not. I didn't do a study.

Q. You haven't done any study?

A. Right.

Q. It's just a general view that you have out there --

A. No.

Q. -- that --

A. It's commonly known in the industry that this is going on.

Q. All right. And when you -- when you say that it's commonly known in the industry, are there -- are there any published studies that talk about this rampant conflict between the folks that are advising the health plans and the PBMs?
A. Not that I know of.
Q. All right.
A. It could be, but it just --
Q. You have never seen any?
A. I haven't -- I haven't referenced it. I didn't discuss it. I didn't footnote it.
Q. Okay. And the -- have you seen any -- in your report, you talk about lawsuits that have been filed against PBMs, and so are there lawsuits against these consulting groups because of their -- this -- this conflict between them and the PBMs?
A. No. The primary -- the primary legal cases that I've been referring to this afternoon involve the steering of the market to more expensive branded products and the games that are being played with generics.
Q. But it's -- it's your view, going back to my question, sir, that -- that health

plans are not being well advised because of conflicts from their consultants?
A. I'm quite suspicious of that. I think everybody is, or most people are.
Q. Is there any congressional investigations which are aware of this or anything like that?
A. No.
Q. When you say it's common -- commonly known in the industry, who have you heard this from? Mr. Bystrom?
A. Among others.
Q. Anybody else you can think of?
A. I heard it from the entire marketing staff at PCN.
Q. Anybody else?
A. Let's see if I've heard it within the consulting industry. I think that I heard it from some of the consultants in the market, but I'm not -- I'm not going to be able to give you the name. I think it came from Anon, A-n-o-n, but I don't --
Q. A-o --
A. I don't have a name. A-n-o-n.

That's one of the large consulting houses. And I don't know if they participate in that. I think the one that's most involved is Express -- is Mercer.
Q. So somebody at Anon --
A. Actually -- I'm sorry. I actually got feedback from one of the Mercer partners that they have these PBMs as clients. And it was the partner in their Portland office, and I don't recall --
Q. What's his --
A. -- his name.
Q. What's his name? But he's in the Portland office.
The Anon, A-n-o-n, that you mentioned --
A. A-n-o-n.
Q. -- does -- does that group provide consulting to health plans?
A. I don't believe they do.
Q. What -- what business are they in?
A. No. I'm sorry. They do provide consulting, not to the PBMs.
Q. How do you know that?

A. We had a discussion about this during the competitive meet marketing structure for the city of Portland about a year to a year and a half ago.
Q. Okay. So in the instance of somebody like Anon that doesn't have the conflicts that you described, are they advising the city of Portland in connection --
A. They are -- they are advising the city of Portland.
Q. All right. And just let me finish my question, if you would.
So in a case like Anon where they're advising the city of Portland, they're presumably in the position to examine the differences between what Express Scripts is -- is offering in terms of rebate dollars, what a Medco is offering in terms of rebate dollars, what PCN is offering in terms of rebate dollars, what each of them is charging for administrative fees and to advise their clients in terms of what's the best deal; right?
A. They would -- that's correct.
Now, I'm going to qualify it again. You can add up all the -- you can add up all the

columns and when you have one company that is offering administrative fees for the pharmacy benefit that's straight up, Here's what we do and charge you for it, versus someone who says, I will come in and do it all for free and I'll give you a check up front for a portion of the rebate, it's a very hard thing for the -- for the customer or for the client not to go with those options.

The reason I'm so skeptical of the numbers that you're throwing around here for Merck-Medco is these companies cannot survive -- and, in fact, they're some of the most profitable in America -- on no revenue. You know, they're giving their core services away and you're telling me that they're passing through almost all of their rebates, and I just -- something doesn't compute here.

Q. What makes you think that Medco is one of the most profitable companies in America, sir? Have you ever looked at their financial statements?

A. I have. I can't --

Q. Okay. What's their net income?

A. I've actually quoted their net

income here, and again, I don't recall which year it was. But give me a second and I'll find it.

Q. What you quoted, sir, was the number of scripts from Medco, not their net income; right?

A. Well, just hold on a second. I'll give you the numbers.

Starting at Page 24, you have the total number of lives covered and on Page 26 for the Big Four, you have the PBM revenue given in millions. So 35 million -- no. That's -- I think that's 30 -- 35 million -- no, it isn't. It's -- it's -- it is -- it's -- this is listed here as 35,000. This is -- the source for this is from Wyeth documents and it is for the year 2003, September 2003. And it's showing Medco's PBM revenue in millions and the units on the Y axis -- this is 35,000. So 35 -- if -- according to this chart, it's 35 thousand million. That's a lot.

Q. Was this 35 billion?

A. That's -- that's the way you'd read that.

Q. Is -- that's the way your chart has it, at least?

A. That's my -- my chart.

Q. All right. And do you think they have 35 billion in revenues?

A. I will just tell you that HSG and Managed Care Diagnostics' report indicated that.

Q. Do you -- to go back to my question, did you -- do you know how many -- do you know what their net income is? Let's assume they had 35 billion.

A. Net versus gross.

Q. Let's assume that they had 35 billion in revenue. Okay. All that money to pay all their employees, pay for all -- everything that they do. Do you know -- do you know what the net income would be of the company?

A. This number is their gross income that would include paying for product. The net would be after product was paid for, is the way I read this.

Q. This is their revenues; right?

A. This is their gross revenues.

Q. Right. So do you know what their net is?

A. I'd have to look it up.

Q. You haven't looked?

A. I did, but I don't happen to have it on the top of my head here.

Q. Do you know if it's -- if they have a 1 percent net income or less?

A. I think it's more.

Q. Do you know if it's -- how much more?

A. I would -- again, I'm going out on a limb here. I have looked at their financial statements. My bet is that they're something less than 5 percent.

Q. Okay. When you say -- you make these --

A. Probably somewhere around 3.

Q. -- these grand statements, okay, which you have a habit of doing, Dr. Gibson -- you said they're one of the most profitable companies in America. All right. And then I ask you what's their net income.

What's the basis for you saying they're the most profitable company in America if you don't know what their net income is?

A. I didn't say they -- they were a --

they were one of the more profitable companies in America is what I said.

Q. Okay. And -- and how can you say they were one of the more profitable companies in America if you don't know what their net income income is?

MR. COHEN: Object to the form.

A. I do -- I do know what it is. I've seen it. I just don't happen to have it with me right now.

BY MR. DOBIE:

Q. Okay. And do you -- and sitting here today under oath, it's your belief that they're one of the more profitable companies in America, Merck-Medco is?

A. They are a -- they are -- they are viewed as a very profitable company.

Q. And are you talking about measured on the basis of -- of revenues to income in terms of their margins? Are you talking about the total dollar amount of their net income? What's -- what's the basis for your most profitable --

A. Return to shareholders and the profitability for shareholders. These are

publicly traded companies.

Q. Are you talking -- so are you including the amount that their stock has gone up?

A. The valuation of their stock.

Q. Okay. All right. So -- so are they -- okay. So you're -- their market capitalization has gone up?

A. Which reflects their profitability.

Q. And --

A. And you -- then you can get the exact number on profitability out of their annual statements.

Q. Now, we're going kind of around and around here, but what you're -- what you're saying is that it's impossible -- your conclusion is, even though you haven't read the testimony of the witnesses under oath, you hadn't ever looked at the document before, but it's your conclusion, Dr. Gibson, that it's impossible that they're paying on 90 percent of their rebate on Premarin to health plans because of the fact that their stock price has increased, and that means that they're one of the more profitable companies in America?

A. That's --

MR. COHEN: Object to the form. Mischaracterizes the testimony.

A. That's -- that's not even close to what I said. What I -- I'll restate where I am.

I'm saying that you are presenting data to us today that we've never seen before that says that -- that Medco is returning percentage of rebates in excess of what PCN does and at the same time Medco is in the market providing their core services at little or no fees to the customers. And I'm telling you I find that not credible. I think that the data you're getting does not include all of their rebate funding.

BY MR. DOBIE:

Q. How many current lives does PCN have, sir?

A. 1,200 -- 1.2 million.

Q. And how many does -- does Medco have?

A. Medco as of June 2001 was stated to have 65 million.

Q. Do you -- do you think that they run a more efficient operation than PCN, sir, and as a result of that they're able to offer health plans

a better deal than PCN?

A. I have no opinion as to whether they're more efficient. I will tell you that adminstrative fees are generally standard across the industry. In other words, you don't -- what the customer sees are administrative fees that are consistent.

I am telling you I do not find it particularly credible that you are being told that -- that Medco has no real substantial revenue, that they give their core services away. The only -- the only way that I could possibly accept that that is realistic is that their 10 percent that they're saving or 20 percent that they're saving, whatever the number is, to themselves is so huge that it represents a substantial amount of money that's not going through to the client.

Q. Or could it also be that they're making money on other products, PPIs? And, for example, do you know how rebate dollars on -- in this therapeutic class, estrogens, compare to the rebate dollars that a PBM makes in other therapeutic categories?

A. Rebates are set by class for a whole host of reasons. I'm totally ignoring now placement and tier positioning and all of that. Within class, the rebate dollars tend to fluctuate on the options available.

So that if -- if -- take the category of serotonin reuptake inhibitors. If there are four options available, the product obtaining favorable positioning on the formulary will generally pay a higher rebate to obtain that than a drug in a class that's exclusive.

Q. Do you know, sir, how many therapeutic classes PCN has on formulary?

A. Classes?

Q. Yes. How many -- how many therapeutic --

A. Probably around 15. I don't -- I don't -- I don't know.

Q. Okay. Do you know what the rebate dollars are in terms of what -- what class most of the rebate dollars fall into? For example, is it in PPIs, is it in estrogens, is it in -- in beta blockers? I mean, do you know -- do you know where most of the rebate dollars fall --

A. You can --

Q. -- at PCN?

A. I'll say I do not know the exact numbers. I can infer where they are, and most knowledgeable people can on just about any PBM's product line. It's a function of the volume of drugs that are used. If you have a low number, the unit cost is low. That's what makes Premarin such an important player, because it's such a commonly prescribed drug, so it doesn't need to be a top-tier cost drug per unit. It generates a lot of rebate dollars because it's a big part of the number of units moved.

If you look at any plan, the actual dollars spent or the units dispensed, the highest tier usually are mental health drugs. Also high frequently are analgesics, and that class can go from nonsteroidals all the way to narcotic analgesics. Somewhere in the middle of the range are usually drugs relating to women's health.

Q. So it's your belief that the dollars spent by a particular health plan on a pharmacy benefit, women's health, that category would fall sort of in the middle of the range, the cost of

the product?

A. Yes, somewhere in the middle tier of total spending would be women's, particularly hormone replacement therapy.

Q. Okay. And do you know -- you've given us your best estimate in terms of where -- where the dollars are spent as it relates to different categories of products here and you've got women's health in the middle.

Do you know whether rebate dollars match that? In other -- in other words, is -- is it a -- do you have -- you said 15 -- 15 classes.

Let me finish the question so Mac can get it down.

If you have 15 classes of products at PCN, as you -- as you testified to, would -- would Premarin be 10 percent of the rebate dollars, would it be 90 percent of the rebate dollars? Do you have any sense of that?

A. Overall, Premarin's -- I'm thinking out loud here to get you an answer.

Overall, the rebate structure for Premarin is at about 10 percent, according to what I read in your documents, which, incidentally, in

the range of rebates is in the midrange. If -- if there were other conjugated estrogens they were actually competing against heads up, it would -- you would expect it to be higher than 10 percent, somewhere between 10 and 15 percent.

But if I could back into the number for what would likely be the rebate number for -- for Premarin and hormonal replacement through Premarin family of drugs, my calculating about 10 percent of what the total revenue -- total cost was to the plan. Now, how that relates to other classes, I've never looked at that.

Q. I mean, I guess what I'm wondering, sir, is just to be clear, you never looked at what percentage of Medco's rebate dollars come from the Premarin family of products versus, let's say, other categories?

A. I don't think that would commonly be available.

Q. Right.

A. Those are all, again, proprietary numbers. You get total numbers frequently, but not -- not by class or by drug.

Q. Have you looked at any documents in

this litigation that give you the amount of rebate dollars paid to any PBMs and compare the amount for Premarin versus any other product that Wyeth sells?

A. I didn't see or study contracts other than for Premarin-related products.

Q. Okay. But did you look -- I wasn't asking about contracts. I asked whether you looked at documents that talk about what percentage of rebate dollars PBMs received from Wyeth for Premarin as opposed to for other products.

A. No.

Q. Okay. So when you testified that you can't believe -- let me -- let me back up.

Do you think these people from Medco are lying?

A. I'm just saying that I'm having trouble with the data you're presenting to me today for the first time. I'm skeptical of that data.

Q. All right. How about like Blue Cross of California? A hundred percent of the rebates dollars passed on is there -- is the

testimony that the contract manager there. Do you think -- do you think that's -- that's also hard to believe?

A. Is that a -- is that a captive PBM for Blue Cross of California? I can't recall.

Q. I'm sorry. Blue Shield of California.

A. Well, okay. Yes. That's a very interesting example. They've got a very different relationship. They have a company known as Argus that administers their pharmacy benefit. That means they do the claims processing. The inhouse people within Blue Shield negotiate all the rebates, manage the network, and so I wouldn't be at all surprised that they would have a hundred percent. I'd be surprised if it was otherwise, because they have fractionated the PBM product into its individual components and all the rebate revenue stays within Blue Shield.

Q. Okay. So -- so it doesn't surprise you that a hundred percent of the rebate dollars would be passed on by -- by Blue Shield?

A. In that model, you didn't -- the word "Medco" didn't ever come up in that sentence.

Q. In Blue Shield of California.

A. Yes.

Q. That doesn't -- that doesn't surprise you?

A. Not for that arrangement --

Q. All right.

A. -- with Argus.

Q. And -- and don't you think, as you mentioned before, given that this is a competitive -- and you say on Page 41 of your report, and you agreed with this, that the PBM industry is aggressively competing for new clients.

Given that that's the case, that you've got people like PCN out there passing on 80 percent of the rebates, Blue Shield of California passing on a hundred percent of the rebates, wouldn't the other PBMs have to pass on a high percentage of the rebates in order to compete with you-all --

MR. COHEN: Object to the form.

A. No.

BY MR. DOBIE:

Q. -- if they're advised by --

A. Because --

Q. Let me finish the question.

-- if they're being advised by consultants, as you -- as you indicated?

A. Even under consultation with a nonconflicted consultant, it's very hard for a customer to take a free gift of administration. Even though they know in the back of their mind that it's going to get paid for on the rebate arrangement, they -- they don't budget the rebate dollars in their yearly financial plan, and truly there's an add-on at the end. So in the marketing environment, they get -- they can go -- these -- these -- these pharmacy managers or benefit managers in most of the companies, like, say, the city of Portland, are middle managers. They're not senior management.

Q. All right. But that's -- at the end of the day, it's a decision that those plans are making then whether to go with a PCN and get 80 percent of the rebates passed on, a Blue Shield of California, a hundred percent of the rebates passed on, or -- or a Medco and get some of the money up front; correct?

A. First of all, Blue Shield is not selling their -- that PBM product as a -- as a --
Q. Let me change my hypothetical.
At the end of the day, it's the -- it's then the decision on the part of these plans whether they want to take some of the money up front and get smaller rebates as opposed to going with somebody like a PCN and having 80 percent or more of the rebates passed on; right?
MR. COHEN: Object -- object to the form.
A. We -- I'm starting to get lost here, but I'm saying that the end of the day, it's the customer that makes the decision.
BY MR. DOBIE:
Q. Yes.
A. We got into this conversation wherein I was skeptical that you were giving me an environment that's too good to be true, that you have a Medco coming in with no administrative fees and greater than the stated PCN rebate returns, and I'm just saying that that doesn't smell right.
Q. You're the one who's saying that there's no administrative fees. My hypothetical

is simply what the man testified to in his deposition. He didn't say they didn't have administrative fees. You've thrown that into my hypothetical.
A. Well, I'm telling you that that's --
Q. That --
A. It's my experience that that's exactly what's going on with that.
Q. Okay. But what -- what I've said is -- is exactly what the witness has testified to under oath, which you haven't reviewed.
A. Right.
Q. All right.
A. And you're saying that in that deposition he said that they're charging administrative fees and they are giving greater rebates than what we have quoted here. That's what he testified to?
Q. He testified that 90 percent of the rebates on the Premarin product were passed on.
A. And what did he say about the administrative fees?
Q. The administrative fees were -- were discussed in relation to how big they were or

small they were, quite frankly, in relation to the rebate dollars, but you don't know about that either. I don't need to educate you, because you haven't done -- you haven't looked at that. It wasn't necessary for you to render your opinions.
A. Okay.
Q. Right?
A. No, it's not right. What I'm -- what I'm asking you --
Q. Was it -- was it --
A. -- is did -- did he testify that he was having administrative fees that he was passing through in tandem with these rebate dollars that you've presented to us.
Q. I can't answer your questions.
A. Oh.
Q. Okay.
MR. COHEN: Gordon, is this --
A. But see, you're the one giving me the --
BY MR. DOBIE:
Q. I'm giving you a hypothetical. I want to get your opinion based upon a hypothetical or a statement of facts from a witness.

A. And my -- my opinion is based on the hypothetical you present is that it's not realistic.
MR. COHEN: Is this a good time to break?
MR. DOBIE: Sure.
THE VIDEOGRAPHER: This concludes today's proceeding in the deposition of David Gibson. The time is 6:03. We're now off the record.
* * *
(Whereupon, the deposition adjourned at 6:03 p.m.)
* * *

INSTRUCTIONS TO WITNESS

Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

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E R R A T A

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ACKNOWLEDGMENT OF DEPONENT

I, _____, do hereby certify that I have read the foregoing pages, _____, and that the same is a correct transcription of the answers given by me to the questions herein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

DATE

Subscribed and sworn to before me this

_____ day of _____, 200_.

My commission expires: _____

_____

Notary Public

C E R T I F I C A T E

I hereby certify that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

It was requested before completion of the deposition that the witness, DAVID J. GIBSON, M.D., have the opportunity to read and sign the deposition transcript.

_____

McKINLEY WISE, CM

Dated: May 28, 2004

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